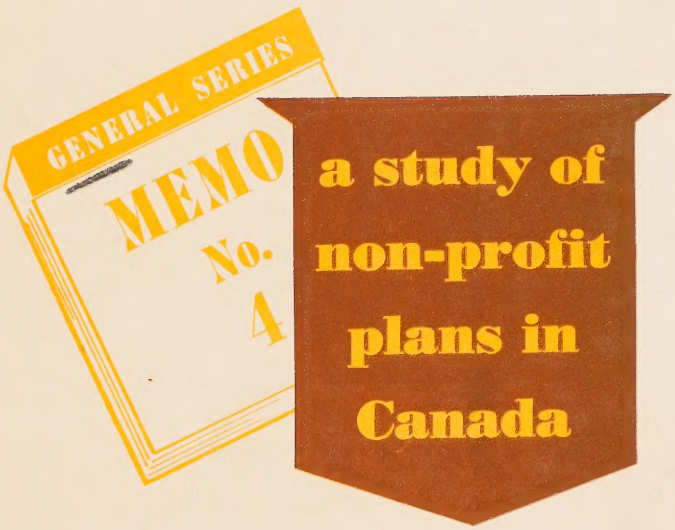
Voluntary Medical Care Insurance



RESEARCH DIVISION
DEPARTMENT OF NATIONAL HEALTH AND WELFARE
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VOLUNTARY MEDICAL CARE INSURANCE:

A Study of Non-Profit Plans in Canada

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FOREWORD

The growth of medical care insurance, particularly in the post-war period, has reflected the widespread public interest in obtaining protection against the economic risks of illness. This publication has been prepared to describe and analyze the operations of fourteen of the voluntary agencies which have been developed under various auspices to offer medical care insurance to the Canadian public on a non-profit basis. It does not cover developments in hospital care insurance under non-profit plans nor the experience of commercial insurance companies in the fields of medical and hospital care.

In planning this study, it was believed desirable to indicate the historical pattern of the growth of the plans. Such a pattern, described in Chapter I, illustrates many of the diverse problems which arise in attempting to design sickness insurance programs to accommodate the uniquely different social, economic and demographic characteristics found in many parts of the country.

An examination of the field of medical insurance requires that such measures of progress as the enrollment in these plans and the rate of their growth, must be related to the extent of protection actually offered the insurance purchaser. Thus in Chapter II, data on the number of persons enrolled in non-profit plans are examined in detail to indicate the scope of the benefits provided under the several

types of insurance contracts, and the nature and level of contractual liabilities assumed by the insuring agencies. Chapter III sets forth the financial operations of these agencies. It is primarily concerned with a general examination of their expenditures on behalf of the insured membership, but includes an analysis of the component items in the payment for medical services, the expenditure pattern as affected by the age and sex of the members, and various indices of the costs of administering such programs. Special attention has also been given in this chapter to the financial relationships between the insurance plans and the very considerable number of physicians providing medical care services to persons with this type of insurance.

The volume of medical care services being rendered to the members of the non-profit insurance plans is, of course, an important aspect of this subject. The volume of consultation and treatment, and surgical and obstetrical services provided by physicians participating in such plans, permits a general indication of the effective demand for medical care by the wage earner and his dependents when he is either partially or, in some cases, almost entirely protected against the direct costs of such services. Indeed, service-cost relationships, as given in Chapter IV, serve to emphasize the factors affecting the benefit expenditures of the insuring agencies, and illustrate the

need for certain limitations on entrance to membership, or on benefit provisions, to meet the actuarial insurance principles underlying the operation of non-profit plans.

The concluding chapter, Number V, contains a convenient summary of the general data in the bulletin. An attempt has also been made to describe briefly some of the special problems which affect the operations of the non-profit plans. The extension of coverage to a larger proportion of the population, the provision of continuity of insurance protection, and the costs involved in medical care insurance both to the individual and the insurance plans, are reviewed in relation to some of the financial and organizational measures taken to meet such problems.

The material contained in this publication has been assembled in co-operation with the non-profit plans. The extensive and continued assistance of their officials, not only in providing very considerable statistical data, but also in offering many helpful comments and suggestions, has made a substantial contribution to the preparation of this document. This generous assistance is gratefully acknowledged. The whole project was also materially assisted by the suggestions and guidance of Dr. F.W. Jackson, Director of Health Insurance Studies, at whose request this study was undertaken.

The work on the bulletin was carried out in the Hospital and Medical Care Studies Unit by John E.E. Osborne, under the supervision of John E. Sparks, and the general direction of C. Lloyd Francis.

April, 1954.

Joseph W. Willard,
Director, Research Division.

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THE FOURTEEN NON-PROFIT PLANS PARTICIPATING IN THIS STUDY

AMS	Associated Medical Services	- Ontario
CMSF	Co-operative Medical Services Federation	- Ontario
GMS	Group Medical Services	- Saskatchewan
MHSA	Maritime Hospital Service Association	- Atlantic Provinces
MMC	Maritime Medical Care	- Nova Scotia
MMS	Manitoba Medical Service	- Manitoba
MSA	Medical Services Association	- British Columbia
MSI	Medical Services Incorporated	- Alberta
MSSI	Medical Services Saskatoon Incorporated	- Saskatchewan
OHA	Ontario Hospital Association	- Ontario
PSI	Physicians' Services Incorporated	- Ontario
QHSA	Quebec Hospital Service Association	- Quebec
SSQ	Les Services de Santé du Québec	- Quebec
WMS	Windsor Medical Services	- Ontario

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I - HISTORICAL DEVELOPMENT

The development of non-profit corporations solely designed to provide insurance protection for the general population against the costs of health care services is one of fairly recent origin in Canada. However, for over fifty years, "check-off" medical-hospital care schemes have been functioning in the industrial areas of Cape Breton, while other industrial and fraternal organizations have been offering prepaid medical services or insurance to their employees or members for several decades.

The growth in Canada of prepayment schemes restricted to medical care insurance dates from the years just prior to World War II, as shown chronologically in Appendix I. The establishment of such schemes was undoubtedly precipitated by the successful operation of Blue Cross plans in the field of hospital insurance in the United States dating from 1932. However, a number of exceedingly important economic and social factors have given impetus to their growth, particularly since 1945. The widening public recognition of the effects of sickness and the costs of its amelioration on the family budget, as well as the rising cost of all of the major expenditure items in the budget, has had a marked influence. Perhaps even more important has been the progress of modern medicine with its increasing emphasis on prevention and early treatment, new techniques in medical management and surgery, discoveries in anti-biotics and chemotherapy, and so on. These, together with the increasing

importance of chronic and degenerative conditions and the treatment services required by a slowly ageing population, have culminated in the need for new, special, and costly skills and facilities, thus placing additional limitations on the family's ability to meet the cost of modern medical care.

The rapid growth in enrollment for all types of medical and hospital insurance in the past fifteen years amply illustrates the Canadian consumer's concern with the cost of his health care requirements and his willingness to seek assistance in meeting one of the major contingencies threatening family security. Apart from the sickness policies now offered by commercial insurance companies and the long-standing plans provided by industrial, occupational or fraternal organizations, the non-profit medical insurance schemes, sponsored for the most part by the medical profession, have grown from a membership of approximately 13,000 in 1939 to over 2 million persons, including dependents, in 1953. Another index of the growth of medical care insurance is that payments on behalf of insured patients represented considerably less than one percent of total payments to physicians from all sources in 1939. In 1952, it has been estimated that from 17-19 percent of total payments to physicians from all sources, both public and private, can be attributed to payments on behalf of patients holding medical insurance protection provided through non-profit, commercial or co-operative organizations.

PRE-WAR DEVELOPMENTS

The pioneer Canadian plan was introduced by Associated Medical Services Incorporated (AMS) in Ontario in 1937. This plan, originally supported and approved by the Ontario Medical Association, offered to pay, on behalf of its members, the complete cost of medical care in the home, office, and hospital, and to make payments towards the cost of hospitalization, the whole not to exceed $800 per member per year, in return for a monthly premium payment by the member.(1) It is significant that this early program, while initially designed to assist members of the Civil Service of Ontario in meeting their sickness costs, has since its inception continued to offer membership to any individual who wished to enroll, rather than restricting membership to groups of employed persons only.

Shortly after the establishment of A.M.S., Windsor Medical Services Incorporated (WMS) was sponsored by the Essex County Medical Society and endorsed by the Ontario Medical Association, with the stipulation that a majority of its Directors must be member-doctors. This plan, now the oldest doctor-sponsored plan in Canada, began enrolling groups of employees from Essex, Kent and Perth counties

(1) This original contract was replaced in 1950 by one which increased total benefits to $1600 including greater per diem hospital benefits, but at the same time reduced medical benefits by removing home and office calls and rescinding the agreement to pay the complete cost of doctors' bills.

(Ontario) in 1939. It chose not to include any benefits to cover the costs of hospitalization, but offered a comprehensive medical insurance contract, including surgical and obstetrical care and physicians' services in the home, office and hospital. The development of this doctor-sponsored program in Windsor was paralleled by a scheme under similar auspices in Regina, Medical Services Incorporated. Also in 1939, under the provisions of the Saskatchewan Mutual Medical and Hospital Benefit Association Act, two mutual benefit associations under consumer sponsorship were established in Regina and Saskatoon, offering comprehensive medical benefits to their membership.

WAR-TIME EXTENSION

The war years saw the establishment of two doctor-sponsored plans in the provinces of British Columbia and Manitoba, and four co-operative or mutual benefit associations in Saskatchewan, Ontario, and British Columbia. Both the doctor-sponsored plans required group enrollment, and both provided a comprehensive range of medical, surgical, and obstetrical benefits through member-doctors under contract with the plans. In British Columbia, the Medical Services Association (MSA), now the second largest doctor-sponsored plan, was set up in 1940, with the approval of both the British Columbia College of Physicians and Surgeons and the British Columbia branch of the Canadian Medical Association, and having medical, employer, and employee

representation on its Board of Directors. Similarly, in 1944, Manitoba Medical Service (MMS) was incorporated under the sponsorship of the Winnipeg Medical Society and the Manitoba Medical Association, which nominate two-thirds of its Board of Trustees.

In 1943, two co-operative medical services associations were established in Ontario, the Credit Unions' Mutual Benefit Association (Cumba) of Toronto, and the Woodstock Co-operative Medical Services Association (Woodstock), but their operations were limited to payment of a portion of the hospital care costs of their membership. Cumba did not enter the field of medical care insurance until 1947. Also in 1943, the Melfort and District Mutual Medical Benefit Association (MMBA) was organized in Saskatchewan, providing its members with a comprehensive range of medical, surgical, and hospital care benefits.(1) The following year a co-operative medical-dental plan, Fraser Valley Medical-Dental Society, was established in British Columbia.

Until 1944, all the medical care contracts offered by the doctor-sponsored plans provided a full range of medical benefits, including surgical, and obstetrical care and physicians' services in the home, office, and hospital. However, in 1944 the Manitoba plan, which now is the third

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(1) In 1951 this plan was disbanded and its 1000 members were absorbed into Medical Services Saskatoon Incorporated.

largest doctor-sponsored scheme, recognizing the need for diversification of its medical contracts so as to provide a choice of coverage to its potential membership, introduced a more limited surgical, obstetrical, and in-hospital medical care policy along with its comprehensive contract. This trend to diversification in the types of contract available was continued in Eastern Canada in the next year. For example, the Windsor plan in 1945 introduced a limited contract providing only surgical and obstetrical care, and the Associated Medical Services introduced a group contract covering surgical, obstetrical and in-hospital medical care, as alternatives to the more comprehensive contracts which they had previously offered. The doctor-sponsored plans which have been established in Eastern Canada since that time have all continued this trend, in contrast with the newer plans in Western Canada.[1]

By the end of 1945, approximately 112,000 persons were covered by four doctor-sponsored, one independent, and four co-operative or mutual benefit plans for some type of medical care insurance as shown in detail in Appendix II.

POST-WAR EXPANSION

The greatest increase in the number of non-profit medical insurance plans operating in Canada, and in the membership of these plans, has occurred following the

(1) But see p. 32 for 1954 developments in limited insurance in the Western plans.

cessation of hostilities in 1945. Nine new plans were introduced in the four-year period 1946 to 1949, four of which were sponsored by the medical associations of the regions in which they operate. By the end of 1949, almost 900,000 persons had been enrolled under non-profit medical insurance plans, and by December 1953, coverage had reached nearly 2.4 million.

This rapid post-war expansion in coverage was influenced not only by the economic and social factors mentioned earlier, but also by two important national developments - wartime Parliamentary activities regarding social security in general, and organized medicine's leadership in fostering the extension of comprehensive doctor-sponsored schemes to cover the whole population gradually on a provincial or regional basis.

(1) Developments in Social Security Planning

Widespread public attention and interest was focussed on the subject of health insurance by the establishment of the Special Committee on Social Security of the House of Commons in 1943. Various aspects of the problems involved in inaugurating a national health insurance scheme were examined in two reports to this Committee - the Report on Social Security for Canada prepared by Dr. L.C. Marsh for the Advisory Committee on Reconstruction, and the Report on Health Insurance prepared by the Advisory Committee on Health Insurance under Dr. J.J. Heagerty. The deliberations

of the Special Committee eventually led to the "Green Book Proposals" of the Government of Canada for the Dominion-Provincial Conference on Reconstruction in 1945-46,[1] which included recommendations concerning public investment, social security (unemployment insurance and assistance, old age pensions, and health insurance), and federal-provincial tax-sharing. No agreement was reached by this conference with regard to the social security proposals, and the emphasis of later discussions was transferred to the tax-sharing proposals which culminated in the taxation agreements of 1947. However, investigations and deliberations on the problems of health insurance were continued beyond 1947 by the various national lay and professional organizations interested in this subject, including the Canadian Medical Association.

(2) The Leadership of Organized Medicine

The Canadian Medical Association in 1947 set up a Committee on Prepaid Medical Care Plans to attempt to co-ordinate the activities of these plans, and to seek a federal charter for a nation-wide service. In its General Policy Statement of 1949, the Association proposed the establishment and extension of voluntary prepaid medical plans, and recognized the right of every Canadian to insure

(1) Dominion-Provincial Conference (1945), Dominion and Provincial Submissions and Plenary Conference Discussions, (Ottawa: King's Printer, 1946), pp. 87-92.

under these plans, with governmental assistance to individuals unable to meet the full cost of premiums themselves. With increasing popular support of such programs, and the development of new plans in several provinces, the Canadian Medical Association gave active leadership, in co-operation with the medically-sponsored plans operating in the various provinces, in setting up in 1951 a central agency to co-ordinate the activities, methods, procedures, and information of the autonomous member organizations, thus further contributing to the eventual achievement of a nation-wide system. This agency, now designated as Trans-Canada Medical Plans and governed by a Commission consisting of one representative from each member plan and one from the Canadian Medical Association, assists the various member plans to design their operations so as to achieve a number of important objectives, including national contracts for employers operating in more than one province, and arrangements to permit the transfer of membership rights between plans. Its ultimate objective is to aid all Canadians, whether in employed groups or not, to enroll voluntarily in medical insurance schemes.

(3) Nation-wide Extension of Operations

In the post-war period, the most significant development in the field of medical care insurance was the introduction in several regions of new doctor-sponsored plans offering comprehensive medical care contracts, as well as the expansion of enrollment under existing plans. In

addition, new co-operative plans were established, and some of the Blue Cross hospital insurance plans extended their operations into the medical insurance field.

(a) Co-operative Plans

The year 1946 saw the establishment of a co-operative plan in the province of Quebec which, prior to this time, had not experienced the development which had taken place in Ontario and the West. Although a few small local co-operatives had existed there for sometime, the organization of a co-operative syndicate, Les Services de Santé du Québec (SSQ), officially approved by La Fédération des Sociétés Médicales de la Province de Québec, and insuring members of credit unions and employed groups against the costs of medical and hospital care, was an extension of the consumer co-operative health movement noted in Ontario and Saskatchewan. Parallel to the establishment of this plan was the organization of the Co-operative Medical Services Federation (CMSF) in Ontario, and the Credit Union and Co-operative Health Services Society (CU & C) in British Columbia in the same year. The former was a federation of the five co-operative associations operating in Ontario, to co-ordinate the activities of the member co-operatives, to give them guidance in providing medical and hospital benefits to their members, and to encourage the extension of the movement which by 1952 embraced 38 Ontario co-operatives, including eight which offered medical benefits. The latter plan, approved in 1949 by the B.C. College of Physicians and

Surgeons, was organized to provide comprehensive medical and surgical benefits to members and employees of credit unions and co-operatives operating in British Columbia.

(b) Blue Cross Plans

In the year 1946 also, there was a most significant extension in the operations of Blue Cross hospital insurance schemes. Such programs had been inaugurated in all provinces except Saskatchewan and Alberta by 1943, but until 1946 were exclusively concerned with hospital bills. In that year, however, the Quebec Hospital Service Association (QHSA)[1] introduced two contracts, providing surgical and obstetrical benefits, and in-hospital medical (non-surgical) benefits, which it sells in conjunction with its hospital insurance contracts. This plan's medical care enrollment is now the largest of any non-profit plan in the country. Two years later the Maritime Hospital Service Association (MHSA), an independent corporation approved by the New Brunswick and Prince Edward Island Medical Associations, inaugurated a medical and a surgical contract for persons enrolled under its hospital contracts, very similar to those offered by the Quebec plan. Since this plan operates in the four Atlantic provinces, each of which has a large rural and self-employed population, it has not confined itself to enrolling employed groups only, but has

(1) Incorporated in 1942.

pioneered a new type of community contract covering a certain proportion of the ratepayers in a school district. Finally, in 1952 the Ontario Hospital Association's (OHA) Blue Cross Plan[1] began offering medical, surgical, and obstetrical benefits in hospital to those participants in its hospital insurance plan who were enrolled in employed groups. Medical coverage under this plan is now the second largest in the province.

(c) Doctor-sponsored Plans

The expansion of the non-profit doctor-sponsored plans in the west in 1946, with the establishment of Medical Services Saskatoon Incorporated (MSSI), reflected the leadership of the medical profession in the whole field of medical care insurance. This new plan, sponsored by the Saskatoon and District Medical Society, and having equal representation of practitioners and subscribers on its Board of Directors, began by offering a comprehensive range of medical benefits to its members, the majority of whom were enrolled on an individual basis owing to the relatively large number of rural and self-employed persons in the area served. With the inauguration of Medical Services (Alberta) Incorporated

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(1) Unlike the Quebec and Maritime plans, which are independent corporations with joint medical-hospital-subscriber representation on their Boards of Directors, the Ontario plan is operated directly by the Ontario Hospital Association itself. The Maritime plan has in addition a representative of each of the four provincial governments on its Board.

(MSI) in 1948, each of the four Western provinces was in a position to offer coverage under a doctor-sponsored plan to all eligible residents. The Alberta plan is sponsored and approved by the Alberta College of Physicians and Surgeons although five-sixths of its directors are laymen.(1) Recognizing the special problems of a sparsely-settled, self-employed population, MSI originally enrolled, in addition to employed groups, community "health groups" which were already in existence, and individual subscribers, for comprehensive medical care insurance; later it discontinued such contracts. It has, however, continued the practice of "experience-rating" which was first adopted by the MSA plan in British Columbia. It should be noted that non-group contracts were introduced by the Manitoba plan in August 1950 for persons unable to enroll in employed groups, and that community contracts were offered in the same year by the Saskatoon plan to persons in rural municipalities. The diversified character of the Canadian population has thus been recognized by these various plans in their experimentation to cover as large a segment of the population as possible while still retaining the basic principles of sound insurance practice. The final major development in Western Canada was the amalgamation in 1949 of the doctor-sponsored Medical Services Incorporated Regina plan, and the consumer-sponsored Group Health Association(2) plan to form Group Medical Services (GMS) of Regina,

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(1) Originally four-fifths were laymen.

(2) Until 1948 this plan was known as the Regina Mutual Medical Benefit Association.

Saskatchewan. This plan, approved by the Regina and District Medical Societies and having equal practitioner and subscriber representation on its Board of Directors, offers a complete range of medical, surgical, obstetrical, and nursing benefits to members enrolled in employed groups.

Although the two original plans in Canada were established in Ontario, extension of coverage in this province was relatively slow until after 1948 when the Ontario Medical Association sponsored a new plan, Physicians' Services Incorporated (PSI), to offer medical insurance benefits to groups of employees throughout this industrial province. In order to make its benefits available to persons at different income levels, and to permit freedom of consumer choice with regard to these benefits, PSI offered its members a choice of three medical insurance contracts at varying premium rates. Surgical and obstetrical benefits were available under all three contracts, and in addition, medical (non-surgical) benefits were provided in hospital under one contract, and in home, office and hospital under another. In order to reach a broader potential market and thus to reduce selling costs, an experiment was conducted between 1951 and 1952 whereby the "in-hospital" medical contract was offered in conjunction with the Ontario Hospital Association's Blue Cross Hospital insurance contract. At the present time, PSI is the largest plan of its type in the country, in terms of both persons enrolled and

expenditures on benefits. Ontario, then, is the only province with five different non-profit plans providing benefits in this field, under the sponsorship of the medical associations, the hospital association, the co-operative movement, and an independent non-profit corporation.

Despite the early growth of the co-operative movement in the Maritime provinces, and the extension of the Blue Cross plan into medical care insurance in the area, no doctor-sponsored plans emerged until the Medical Society of Nova Scotia organized, sponsored, and approved Maritime Medical Care Incorporated (MMC) in 1949 to provide medical insurance benefits to groups of employees and to members of service clubs or other societies in that province. As in the case of PSI, two-thirds of its Board of Directors must be doctors. With ten years of experience of plans elsewhere in Canada upon which to draw, this plan chose to offer both a comprehensive and a limited benefit contract to members of communities, clubs, and employed groups, and at the same time pioneered two new fields. It designed a contract to cover the dependents of servicemen who were themselves not in need of coverage, and also arranged to operate the Provincial Government's plan for providing limited medical care to certain persons in receipt of public assistance.

The expansion in enrollment under fourteen of these medical insurance plans for which data were provided is shown in detail in Appendix II, where it may be noted that between 1946 and 1953 there was a thirteen-fold increase in coverage from 167,000 to 2.4 million persons. A detailed description of the numbers of persons covered for various benefits under these plans is the subject of the following chapter, while Chapters III and IV deal respectively with the financial and utilization experience of the plans. The federation of plans offering medical insurance contracts, Trans-Canada Medical Plans, is discussed in the concluding chapter.

II - COVERAGE AND BENEFITS

About 1.6 million persons, or 11 percent of the total Canadian population were covered on December 31, 1951 for some type of medical care benefits, either limited or comprehensive in scope, under the voluntary non-profit plans[1] established in this country. Although complete information is not available for 1953, it is estimated that 2.4 million persons, or 16 percent of the total population were covered by the end of that year under such plans. A true portrayal of the extent to which Canadians are protected against the risk of illness under these plans, however, cannot be given without relating enrollment statistics to the type of protection available under the various contracts written by the plans. Contracts differ widely as to the range of benefits provided, and even when the same benefits are offered by different plans, these may be modified by quite

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(1) It has been estimated that as of December 31, 1951, 1,751,000 persons were enrolled for surgical expenses, and 819,000 covered for medical (non-surgical) expenses by commercial insurance companies, after allowing for duplication of coverage. Of these numbers, 290,000 and 119,000 respectively were enrolled under individual rather than group contracts. See Financing Health Services in Canada prepared by the Joint Committee on Health Insurance of the All Canada Insurance Federation and the Canadian Life Insurance Officers Association (Toronto, 1954), pp. 19-23.

The number of persons covered under programs operated by industrial organizations or government bodies for their employees, or those purchasing protection from fraternal bodies, credit unions and so on, is not available at the present time.

different waiting periods or other exclusions or limitations. For this reason, this chapter analyzes coverage data in terms of the types of contract under which subscribers are enrolled, and the benefits extended by each type of contract.

As of December 1951, British Columbia, Manitoba, and Quebec had the largest percentages of their population enrolled for medical care benefits, from 14-16 percent as indicated in Table I, while Alberta and Saskatchewan had the smallest. By the end of 1953, Manitoba had expanded its enrollment to 21 percent of its population, Ontario to 18 percent, and Saskatchewan to 14 percent, as shown in Chart I. When considering the proportion of the total population enrolled, as one measure of the effectiveness of non-profit plans, it must be borne in mind that such plans have had to devise their programs to conform to certain fundamental principles of established insurance practice. The extent to which such factors as the age, health or employment status requirements of the various plans limit eligibility for membership is discussed at the end of this chapter.

Table 1. TOTAL ENROLLMENT, AND PERCENTAGE OF POPULATION ENROLLED, UNDER NON-PROFIT[a] MEDICAL INSURANCE PLANS, BY PROVINCE, DECEMBER 31, 1951 AND 1953

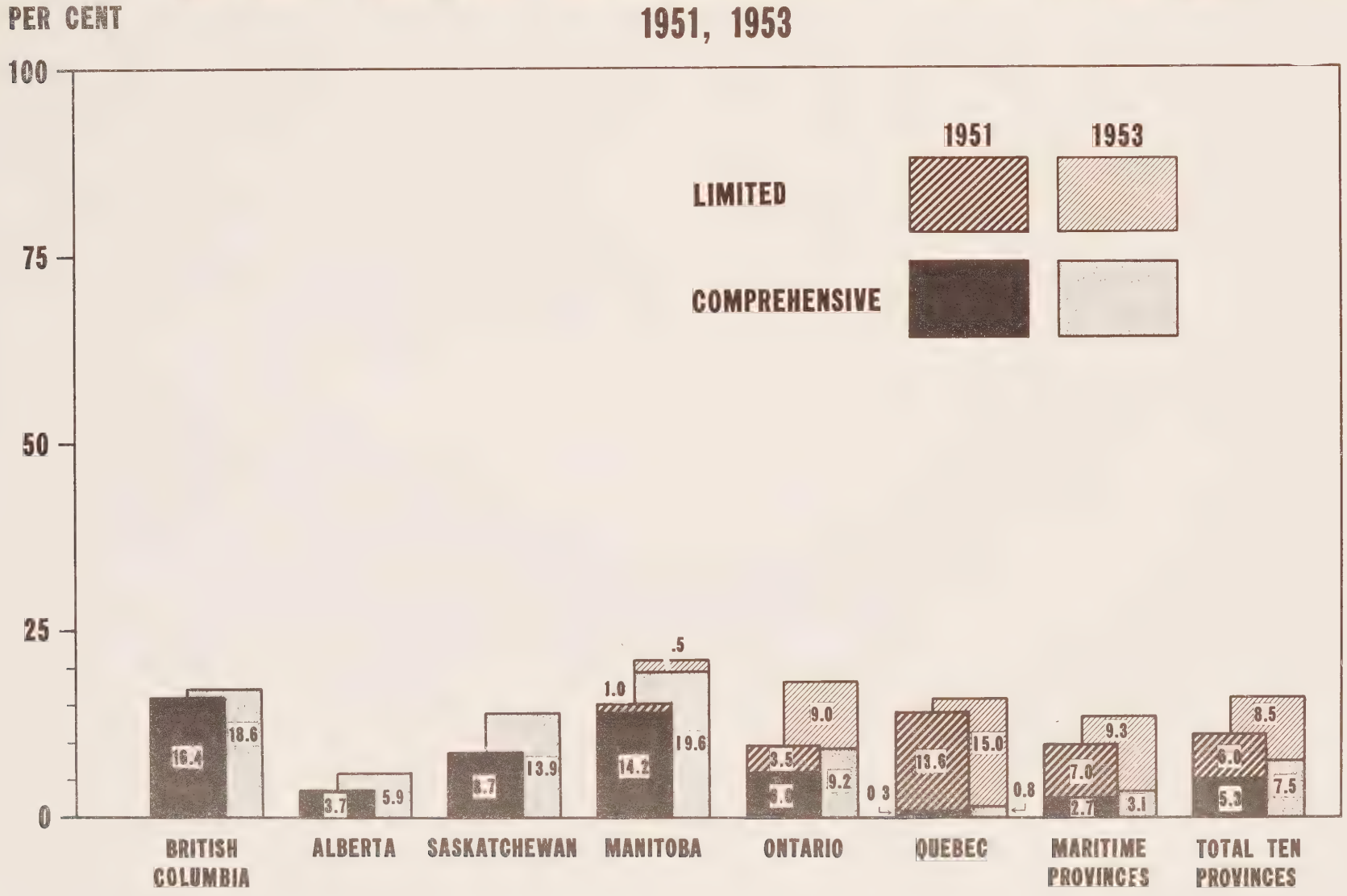
Province	Population		Enrollment		Enrollment as Percentage of Total Population	
	1951[b]	1953[c]	1951	1953	1951	1953
	(000's)	(000's)				
British Columbia	1,165	1,230	190,815	228,685	16.4	18.6
Alberta	939	1,002	34,965	58,827	3.7	5.9
Saskatchewan	832	861	72,538	119,298	8.7	13.9
Manitoba	776	809	118,210	171,011	15.2	21.1
Ontario	4,598	4,897	435,327	890,084	9.5	18.2
Quebec	4,056	4,269	569,694	676,414[d]	14.0	15.8[d]
New Brunswick	516	536				
Nova Scotia	643	663	156,308	209,140	9.7	12.4
P.E.I.	98	106				
Newfoundland	361	383				
Canada	13,984	14,756	1,577,857	2,353,459	11.3	16.0

Source: Appendix II.

(a) Excluding commercial insurance, industrial, and some co-operative plans.
(b) Census data for 1951, excluding N.W.T., but including institutional, armed forces, and Indian population, and those covered under public medical care schemes for indigents, the Swift Current program, and the Cottage Hospital schemes in Newfoundland. If these persons are excluded, it is estimated that the percentage of the population covered in 1951 would increase to about 12 percent, and in 1953 to about 17 percent.
(c) Based on Intercensal estimates of the Dominion Bureau of Statistics.
(d) Estimates.

CHART 1

PERCENTAGE OF TOTAL POPULATION ENROLLED FOR COMPREHENSIVE AND LIMITED BENEFITS, NON-PROFIT VOLUNTARY MEDICAL INSURANCE PLANS, BY PROVINCES 1951, 1953



Source: Tables 1, 4 and 7

CLASSIFICATION OF PLANS

(1) Service and Indemnification Plans

Before a comparison of the benefits offered by the 14 medical care plans operating in Canada is attempted, it is helpful to classify these plans in two different ways - according to their methods of paying for the benefits received by their members, and the scope of the benefits that are available to their members under different contracts. "Indemnification" plans guarantee to reimburse the individual member for his medical care expenses up to certain fixed maximum sums for each type of service received, and do not enter into contracts with doctors to accept the amounts paid by the plans as full payment for services rendered. Charges beyond these maxima are the responsibility of the member.(1) "Service" plans, strictly speaking, guarantee to pay the full cost of medical care services rendered to their members. The latter plans usually enter into contracts with doctors (or their professional associations) who agree to accept the fees paid by the plans as full payment for services rendered. For example, an indemnification plan might agree to pay its members $3.00 for each hospital visit by a physician, or $100 for an appendectomy. If the surgical operation cost the patient $125. or if the physician charged $4.00 for each hospital call, the patient would not be reimbursed for the full amount of his bill. A service plan, on the other hand, might have a similar fee

(1) By retaining responsibility for assuming some portion of these charges, the member is in effect "co-insuring" his own risk.

schedule which also pays a physician $3.00 for a hospital visit, and a surgeon $100 for an appendectomy, but, because of his contract with the service plan, the doctor cannot charge member-patients more than these amounts for these services. The patient is not called upon to pay any additional fee out of his own pocket.

There is, however, only one plan in Canada - Manitoba Medical Service - which meets this rigorous definition of a "service" plan[1]. Consequently, it is necessary to make a further distinction between "full service" and "partial service" plans. While the former guarantee to pay the full cost of all medical care services, the latter guarantee to pay the full cost of general practitioner care rendered to their members by doctors under contract, but permit certified specialists to charge additional fees for their services if they so wish. Of the nine service plans then, one meets the "full service" definition and eight are "partial service" plans. Of the latter, five also meet the full cost of diagnostic services, and three of these pay full x-ray costs.[2] One of the five "indemnification" plans, - the Ontario Co-operative Federation - although it

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(1) However, the B.C. plan meets the full cost of any necessary general practitioner and referred specialist services, and two other plans offer full service benefits to their low-income subscribers and dependents as discussed on pp.36-37.

(2) Full costs here mean the scheduled fees for these items, less any discounts that may have been agreed upon by the plans and their participating doctors.

has no contracts with practitioners, agrees to pay the minimum fees set forth in the provincial Medical Association's fee-schedule, but requires members to meet the first $15 of any professional charges. Members are also responsible, of course, for any charges in excess of the scheduled minimum fees.

Indemnification plans, which reimburse members for medical expenses incurred, covered 766,033 persons at 31 December 1951, while service contracts, which pay the full cost of at least general practitioner care, covered 804,824 persons on the same date. By the end of 1953, the numbers covered had increased to an estimated 1,140,000 and 1,210,000 persons respectively. In percentage terms, 49 percent of the covered population were enrolled under indemnification plans, and 51 percent under service plans in both years. By contrast, developments in this field in the United States have been largely in the form of indemnification plans. It is estimated that 67 to 75 percent(1) of Blue Shield members in the United States were entitled to receive cash indemnities in 1950,(2) a pattern very different to that developed in Canada.

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(1) If the 3 million members of comprehensive independent plans were included in the total, then 56 to 63 percent of all persons insured for medical benefits in the United States in 1950 were entitled to receive cash indemnities.

(2) Most of these were not eligible for service benefits because they earned above the stipulated income limits; the average limits in 1949 were $2050 for single persons, and $3100 for families. By 1952 the average income limit for families had risen to $3500.

(2) Comprehensive and Limited Programs

The second method of classifying medical care plans is based on the scope of the benefits provided to the subscribers to the various contracts. A "comprehensive" contract might be defined as one which provides a wide range of benefits, including payments for each of the following services: physicians' calls in office, home and hospital; consultations; surgical operations and procedures; confinements; anaesthesia; and x-ray, laboratory, and other diagnostic procedures. A "limited" contract would be one which provides only a limited selection of these benefits, such as surgical and obstetrical care, with or without medical (non-surgical) care in hospital.

At the end of 1951, 735,000 persons or 5.3 percent of the total Canadian population were enrolled under the 13 "comprehensive" contracts which were written by the 9 service plans in operation at that time. An additional 836,000 persons[1] - 6 percent of the population - were covered under 16 "limited" contracts offered by 5 of these service plans and 4 indemnification plans. Thus, as mentioned previously, about 11 percent of the Canadian population by the end of 1951 had some protection through

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(1) It will be noted that the sum of these two figures is less than the total given in Table I. It has been estimated that an additional 7,000 persons were enrolled for comprehensive benefits under the co-operative associations in Saskatchewan but information about these plans has not been included in this bulletin.
Over 60,000 persons, or 4 percent of the covered population, were enrolled under "non-group" contracts, as discussed on pp. 64-65.

non-profit plans against the costs of illness. By December 1953, with one additional indemnification plan in the field, 1,105,000 persons or 7.5 percent of the population were covered under comprehensive contracts, and 1,250,000 persons (8.5 percent) under limited contracts. Although 17 percent of the United States population (25 million persons) were insured for some medical care benefits through non-profit plans in December 1951, only 2.4 percent had comprehensive coverage.(1) It is of interest to note that, whereas 47 percent of the enrolled population in Canada had comprehensive coverage at that time, only 14 percent of the enrolled persons in the United States had such coverage. It should also be mentioned that all of the Canadian "comprehensive" plans were operating on a "service" basis in 1951, whereas 7 of the 11 American Blue Shield comprehensive plans operated on a straight cash indemnity or a part-service, part-cash indemnity basis depending on income limits. Twenty of the 46 U.S. Blue Shield plans operating on such a "split-benefit" basis in February 1952 had set income limits of $3500 or less on their family contracts to restrict eligibility for "service" benefits. Of these plans, thirteen had chose $3000 as the limit for family contracts.(2)

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(1) The President's Commission on the Health Needs of the Nation, Building America's Health, Vol. 4, Financing A Health Program For America, (Washington: Government Printing Office, 1953) p. 327.

(2) O.N. Serbein, Jr., Paying For Medical Care in the United States, (New York: Columbia University Press, 1953), Table 73, pp. 140-1.

A classification of Canadian medical care contracts both by range of benefits - comprehensive or limited - and by type of plan - indemnification, full service, or partial service - is given in Table 2.

The figures for the annual postwar enrollment under the comprehensive and limited contracts available in the various provinces are summarized in the following sections. Complete enrollment statistics for each plan are given in Appendix II.

Table 2. CLASSIFICATION OF MEDICAL CARE CONTRACTS OFFERED BY FOURTEEN NON-PROFIT INSURANCE PLANS, BY TYPE OF PLAN, AND BY RANGE OF BENEFITS PROVIDED, DECEMBER 31, 1952

"Indemnification" Plans	"Service" Plans							
	Full Service		Partial Service					
			(a) Full Cost of G.P. Diag. & X-Ray Services		(a) Full Cost of G.P. and Diagnostic Services		Full Cost of G.P. Services Only	
Limited	Comprehensive	Limited	Comprehensive	Limited	Comprehensive	Limited	Comprehensive	Limited
Ont. AMS - "900" - "1600" - "GMS" Ont. OHA - MS&O Ont. CMSF(g) Que. QHSA - (h) - MS&O - S&O Maritime MHSA-MS&O(h) -S&O	Man. MMS - "B" Ont. AMS - - "800"(e)	Man. MMS "A"(b)	B.C. MSA Alta. MSI Ont. WMS(d) - MS&O		Ont. PSI - Blue N.S. MMC - MS&O	Man. MMS(c) - Ltd. Ont. PSI - - Green - Brown Ont. WMS(d) - S&O N.S. MMC - S&O	Sask. MSSI -A, -B, -Community -Individual Sask. GMS Man. MMS(c) -Extd. Que. SSQ(d) -A&B(f)	Que. SSQ(d) - A -B(f)

(a) The full cost to the patient, after any discounts of the scheduled fees for these items which may have been arranged between the plan and its participating doctors. Certified specialists (e.g. radiologists) may of course charge extra fees.
(b) X-Ray services are limited under this contract.
(c) Specialists are not permitted to charge extra fees.
(d) Above certain income levels, general practitioners are free to charge extra fees to member patients.
(e) Terminated February 1950.
(f) A maximum of $200 is allowed for surgical procedures.
(g) Member pays first $15.00 of any professional charges.
(h) These plans are considering the introduction of comprehensive contracts in 1954.

Note: Appendix III gives a description of the contracts listed here.

COMPREHENSIVE INSURANCE

COVERAGE

Comprehensive contracts in 1951 were offered only by "service" plans, most of which are sponsored by medical associations, and all of which are approved by the profession. Under these contracts, medical, surgical, and obstetrical care in home, office and hospital is available to all subscribers. Such comprehensive benefits were offered to about 47 percent of all persons enrolled under the non-profit plans for some type of medical care in 1951, 1952, and 1953.

Enrollment under comprehensive medical care contracts increased from about 154,000 in 1946 to 735,000 in 1951, and to 1,105,000 in 1953, with an increase of almost 95 percent between 1950 and 1953. Over the last three years, however, the rate of growth has been steadily declining as is indicated in Chart 2. The enrollment under each of the 10 plans offering comprehensive insurance during this period is given in Table 3. A steady expansion in enrollment, particularly of younger, comparatively healthy persons, is extremely important for the voluntary non-profit plans, since their operating principles require that a certain proportion of the membership make no claims on the plan initially. Membership growth becomes increasingly important as the proportion of the members in the older age groups increases.

Table 3. NUMBERS OF PERSONS ENROLLED UNDER "COMPREHENSIVE" MEDICAL CARE CONTRACTS, BY PROVINCE AND PLAN, TEN NON-PROFIT "SERVICE" PLANS, DECEMBER 31, 1946 - 1953

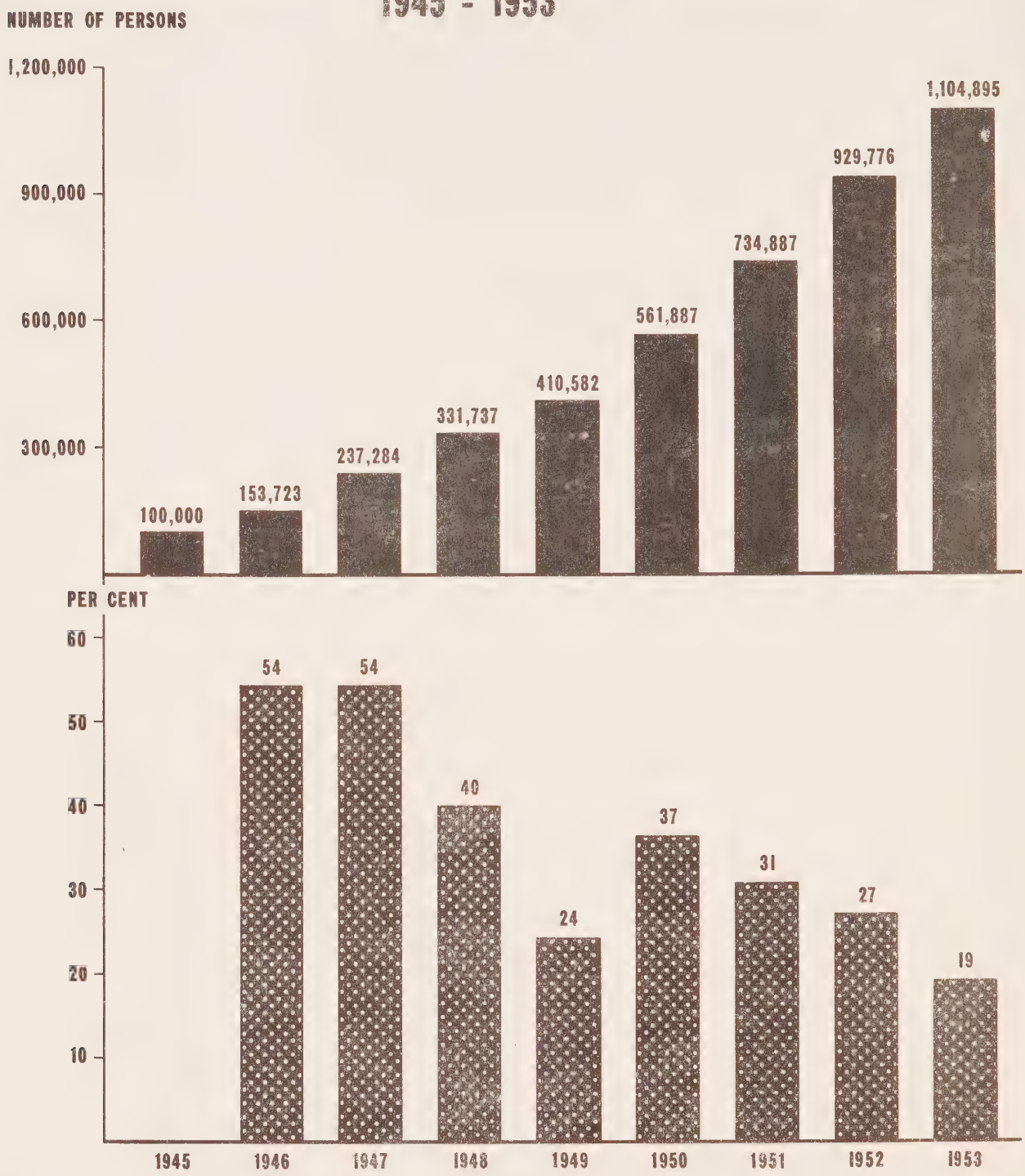
Province-Plan	1946	1947	1948	1949	1950	1951	1952	1953
B.C. - MSA	59,051	97,709	126,279	140,454	164,494	190,815	204,770	228,685
Alta. - MSI	-	-	3,892	23,513	36,218	34,965	44,200	58,827
Sask. - MSSI	8,297	13,188	16,532	24,932	35,405	48,352	74,382	92,530
GMS	4,689	5,475	6,161	9,800	11,908	17,186	22,281	26,768
Total	12,986	18,663	22,693	34,732	47,313	65,538	96,663	119,298
Man. - MMS	27,287	28,327	43,080	53,508	76,740	109,889	130,928	158,632
Ont. - PSI	-	-	18,689	38,818	103,378	170,757	260,000a)	313,321
WMS	16,610	47,757	68,953	74,521	92,394	104,698	121,215	139,003
AMS	37,444	41,328	41,751	26,136	-	-	-	-
Total	54,054	89,085	129,393	139,475	195,772	275,455	381,215a)	452,324
Que. - SSQ (a)(b)	345	3,500	6,400	8,900	11,800	13,900	21,000	35,000
N.S. - MMC	-	-	-	10,000	29,550	44,325	51,000	52,129
CANADA	153,723	237,284	331,737	410,582	561,887	734,887	929,776	1,104,895
Annual Rate of Growth	54%	54%	40%	24%	37%	31%	27%	19%

Source: Appendix II

(a) Estimates.
(b) On the assumption that persons enrolled under both contracts "A" and "B" are entitled to a comprehensive range of benefits, estimates have been made of this dual enrollment.

CHART 2

NUMBER OF PERSONS COVERED AND PERCENTAGE INCREASE IN ENROLLMENT OVER PREVIOUS YEAR, UNDER COMPREHENSIVE MEDICAL INSURANCE CONTRACTS, 1945 - 1953



Source: Table

The two plans with the largest enrollment under comprehensive contracts at the end of 1953 were Physicians' Services (Ontario) and the British Columbia plan, having 313,000 and 228,000 members, respectively. Ontario had the greatest number of persons enrolled for comprehensive benefits (452,000), representing about 9 per cent of the province's 1953 population. Manitoba, on the other hand, had 20 per cent of its population so enrolled, while British Columbia had almost 19 percent, as shown in Table 4. Quebec had less than one percent of its population (35,000 persons) enrolled for comprehensive medical care. The overall Canadian enrollment was 7.5 percent of the total Canadian population.

Table 4. ENROLLMENT UNDER "COMPREHENSIVE" MEDICAL CARE CONTRACTS AS PERCENTAGE OF TOTAL POPULATION, BY PROVINCE, 1951 AND 1953

Province	Percentage Enrolled	
	1951	1953
British Columbia	16.4	18.6
Alberta	3.7	5.9
Saskatchewan	8.7	13.9
Manitoba	14.2	19.6
Ontario	6.0	9.2
Quebec	0.4	0.8
Nova Scotia	6.9	7.9
CANADA[a]	5.3	7.5

(a) Comprehensive contracts were not offered in the other three provinces by any Blue Shield type plans until 1954.

In all the plans offering their members a choice between comprehensive and limited contracts, the comprehensive contracts appear to be the most popular. For example, as Table 5 indicates, of the five plans which provided such a choice in 1953, three plans had over 90 percent, one plan over 80 percent, and one had almost 70 percent of their total membership enrolled for comprehensive care. In four other plans covering 407,000 persons in 1953,(1) only comprehensive contracts were offered.

Table 5. ENROLLMENT UNDER "COMPREHENSIVE" MEDICAL CARE CONTRACTS AS PERCENTAGE OF TOTAL ENROLLMENT' FIVE NON-PROFIT INSURANCE PLANS, 1951 AND 1953

Province	Plan	Percentage Enrolled	
		1951	1953
Ontario	W.M.S.	98.9	99.1
Nova Scotia	M.M.C.	98.5	99.2
Manitoba	M.M.S.	93.0	92.8
Ontario	P.S.I.	78.3	80.1
Quebec	S.S.Q.(est)	52.9	68.0

SCOPE OF BENEFITS

While it has been possible to include in this bulletin current data presenting statistical information on the number of persons covered and the general financial operations of the plans to the end of 1953, the following

(1) In 1954, this pattern may change considerably. Plans in the three western provinces are introducing limited contracts, while plans in Eastern Canada are considering introducing comprehensive service contracts.

material regarding the benefit provisions of the various medical insurance contracts and the numbers enrolled thereunder relates very largely to the year 1951, since this was the latest year for which complete information on benefit provisions was collected.

Although comprehensive contracts have been defined as those which offer a complete range of benefits to members, it is extremely difficult to draw comparisons even among those plans which seem to be offering similar packages of benefits, since different waiting periods, exclusions, and other limitations are enforced by each plan. This factor must be borne in mind whenever a comparison is made of the services offered by different plans, with regard either to the volume of the services themselves, or to the cost of providing the services to members. An outline of the benefits offered by each plan, at December 31st, 1951, by type of contract, is given in Appendix III.

In providing benefits to their members, the comprehensive plans have deliberately chosen to go beyond the limits which the strictest application of insurance principles would impose on the scope of benefits offered. To illustrate, events which will in all probability occur in the near future are not considered good insurance risks. Immediate treatment for pre-existing conditions, and home and office calls, are generally considered to fall in this

category. However in order to provide a really comprehensive range of services, including preventive measures, these plans have developed their programs to provide such services which, however costly, are considered essential for adequate protection.

(1) Contractual Limitations

The contractual liability of the voluntary plans is generally limited in three ways,[1] depending on (a) the physician who renders the service, (b) the nature of the service, and (c) the patient's duration of membership. Specialists are usually remunerated at general practitioner rates, and are free to bill patients for the difference between these and the regular specialist rates. Dollar limits may be imposed on ancillary benefits such as x-ray and diagnostic services. Waiting periods are enforced before treatment for certain types of conditions is available. The most important of these limitations is that placed by the plans on their liability to meet the costs of services performed by specialists. There are at present no available data on the extra cost to the patient resulting from these limitations.

(a) General Practitioners and Specialists

All nine of the service plans offer contracts (covering 1,105,000 members in 1953) which guarantee to pay

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(1) For reasons which are discussed on p. 52-53.

the complete cost of all necessary preventive, diagnostic or therapeutic services performed by general practitioners in the home, office, or hospital,(1) either by paying the physician directly or, in exceptional circumstances, by reimbursing the patient for his expenditures.

However, as noted previously, only the Manitoba Medical Service offers a "full service" contract to all its members, which entitles them to the complete cost of referred or non-referred specialist care without risk of "extra-billing"(2); only 14 percent (147,533 persons) of all persons covered for comprehensive insurance in 1953 were enrolled under this type of contract. The Medical Service Association of British Columbia, however, is a full service plan to the extent that it pays the full cost(3) of general practitioner and referred specialist services. The Windsor plan, as discussed below, employs an income limit to determine whether a member is or is not entitled to the full cost of specialist services. Originally "extra-billing" was not permitted under the British Columbia, Saskatoon, or Windsor plans, and the extent to which it is now practised

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(1) One plan will not pay general practitioner claims exceeding $37.50 per persons per month for hospital and home calls for paediatrics; one of its contracts also limits office calls to twelve per year.

(2) But this plan will not pay specialist claims exceeding $50 per person per month for hospital and home visits for paediatrics.

(3) Except when, by a definite prior agreement which is mutually satisfactory to the patient and the doctor, the patient assumes full responsibility for the costs of any "extra" services he requests.

under the eight plans which permit it is not known. In actual practice it appears that many specialists accept the rates paid by the plans as full payment for the services they render to member-patients.

In addition to the basic treatment services, all persons enrolled under comprehensive contracts were eligible to receive any necessary consultative services upon referral from one general practitioner to another, without limitation. However, the full cost of consultations upon referral to specialists, as in the case of specialist treatment services, is not generally guaranteed by the service plans, since only one plan contracts to meet specialists charges in full.(1)

A further restriction on the contractual liability of plans to meet the cost of physicians' services is the use of income limits by the Windsor and Services de Santé plans. Until May, 1953, participating physicians were permitted to charge additional fees at the time of service, only to those married members of the Windsor plan earning more than $6,500 annually, and to those single persons earning more than $3,000; at that date, the income limit for single subscribers was raised to $4,000. Neither general practitioners nor specialists under this plan may charge extra fees for services rendered to members who earn less than these

(1) However, two plans covering some 151,000 persons in 1953, pay the full cost, at specialist rates, of the first consultation only.

amounts. The Services de Santé plan adopts a slightly different approach to this problem. As of 1951, participating general practitioners, and specialists providing examinations or treatment services, might not charge more than the scheduled rates for their services, when their patients earned less than $2,400 if married or $1,500 if single; additional sums might be charged if a patient's income exceeded these limits. For referred consultations or treatment by specialists, however, the plan meets only 50 percent of the scheduled rates, and the specialist is not permitted to charge the patient more than the remaining 50 percent, when his income is less than the above limits. With less than 175,000 persons, or 16 percent of all comprehensive contract enrollees, covered under these plans in 1953, it is obvious that income limits do not present a serious barrier to most persons subscribing for comprehensive "service" benefits.(1)

(b) Dollar Limits on Ancillary Benefits

With the increased use of diagnostic and laboratory facilities, some plans have necessarily imposed dollar limits on their liability for certain ancillary services, although again, in terms of the total Canadian coverage, these limitations have affected only a minority of the insured persons. By 1951, maximum limits of $25 and $35 had been set by two plans on the total payments they would make for diagnostic x-ray, laboratory, and all other

(1) For comparable American experience, see p.23.

diagnostic services for any of their 56,000 members[1] in a year. For an additional 247,000 persons, or one-third of the comprehensively-insured population in 1951, diagnostic x-ray services alone were subject to limits varying from $25 to $50 per person per year, or from 50 to 75 percent of total cost, or a combination of these. On the other hand, very few plans impose dollar limits on payments for x-rays in fracture cases, since fractures occur infrequently enough to be considered an "insurable risk", and are not usually a serious cost problem. Only about 5 percent of the persons insured for comprehensive benefits were subject to fracture x-ray limitations in 1951.[2] Basal metabolism tests, blood counts, urinalyses, electrocardiograms, and other laboratory and diagnostic services were available without extra charge to all but 12 percent[3] of those persons with comprehensive protection.

It is evident, then, that the plans enforce dollar limits on particular items of service, rather than on total expenditures per patient, in order to restrict their total liability for benefits. In fact only two plans, with some 58,000 members in 1951, have found it necessary to impose

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(1) Almost 33,000 of these were enrolled under "non-group" contracts, insuring individuals who were not members of employed groups.

(2) Three contracts covering 39,000 persons guaranteed to pay 50 or 75 percent of such costs, or maxima of $35 or $50.

(3) Including the 56,000 persons mentioned above. In all, 7 contracts covering 87,000 persons in 1951 limited payments for these services to from $10 to $50, or 50 percent of the scheduled rates.

annual limits on total payments for medical care benefits, amounting to $400[1] and $500 per person.

(c) Waiting-Periods

The third method by which a plan limits its liability to pay benefits is by requiring that new members undergo waiting-periods before they become eligible to receive benefits; but, as with dollar limitations on ancillary services and income limits on eligibility for benefits, this restriction affects only a minority of the comprehensive contract members. Most benefits were immediately available to 683,000 persons under 11 comprehensive contracts in 1951. Waiting periods of one or two months, however, were required under 3 contracts before their 52,000 members[2] became eligible for any medical care benefits. Insurance principles suggest that waiting-periods are desirable in order that the contributions of beneficiaries may be accumulated before expenditures are incurred on their behalf, and that persons may be discouraged from enrolling to obtain a particular benefit and then withdrawing. In this way a plan is assured of having more contributors than recipients of benefits at any given time. The limited use of waiting periods by the Canadian comprehensive plans indicates their concern with the immediate extension of basic protection to

(1) This limit only applies to persons who have left covered employment and convert to an individual contract.

(2) Almost 35,000 of these were enrolled under "non-group" contracts.

their members. Treatment for specific conditions, particularly confinements and surgery, however, was subject to waiting-periods of from 6 to 12 months under some of the plans.

(i) Confinements. The most common benefit which entails a waiting-period is attendance as confinement. To illustrate, 60 percent of all comprehensively-insured persons (439,000) in 1951 were enrolled under contracts which withhold maternity benefits until after 10 months of family membership. An additional 36 percent subscribed to contracts which require 9 months of such prior membership.(1) A 12-month wait was imposed on 8,000 persons under another contract. In fact, only 2 contracts, with 20,000 members, dispensed completely with waiting-periods in the case of confinements.(2) It should be noted however, that "extended maternity benefits" are available to former subscribers of the B.C. plan for a period of 9 months following termination of membership.

(ii) Pre-Existing Conditions. Restrictions on treatment for conditions which had existed prior to enrollment do not apply to the majority of persons comprehensively insured. About 63 percent of members with comprehensive coverage

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(1) The Alberta plan will accept 9 months of single membership.

(2) See waiting-periods for "Obstetrical Surgery" in Table 6.

(461,000 persons under 6 contracts) were eligible in 1951 for such treatment as soon as they enrolled. At that time, waiting-periods of 6 months, 10 months, and 12 months were required under 3 other contracts before newly-insured persons among their 221,000 members could be treated for such pre-existing conditions. While four contracts with 53,000 members[1] specifically excluded treatment for these conditions from their benefits, the Saskatoon plan has found that less than one member in ten has an exclusion due to a pre-existing condition.

(iii) Surgery. The provision of surgical benefits requires special attention since some plans have limited their liability for such benefits by a combination of waiting-periods and dollar limits, together with the previously-mentioned "extra-billing" privilege extended to certified specialists.

All of the plans set forth schedules of the fees they will pay for surgical operations. If a specialist wishes to charge more than the fee listed, he may assess the patient for this extra sum under any but the one "full service" plan which pays specialists in full (Manitoba), or the two "partial service" plans, (Windsor, S.S.Q.) which do not permit specialists to "extra-bill" their low-income

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(1) It should be noted that almost 33,000 of these persons were enrolled under "non-group" contracts. Because of the greater probability of enrolling "poor health risks" under such contracts, restrictions on treatment for pre-existing conditions are imposed.

subscribers. The Alberta and British Columbia plans require that their members be informed of such extra charges in advance, although referred specialist services are usually paid in full by the latter plan.(1) Apart from this provision, no further limitations on general surgical benefits were imposed in 1951 on 92 percent (679,000) of all comprehensively-insured persons. Two contracts, covering 42,000 persons, required their members to undergo 2 or 3 month waiting-periods before any surgical benefits were available. Another limited payment for surgical benefits to a maximum of $2000 per operation.

Because of the insurance risk involved in making certain benefits available to members immediately, particular surgical operations also carry certain waiting-periods which must be undergone before new members are eligible to receive such benefits. These periods vary from one plan to another, and from one operation to another. A representative list of surgical operations is given in Table 6, with the 1951 enrollment figures of plans imposing waiting-periods from 6 months to 2 years, of which the majority were one year or less.

(1) The Regina plan also will pay specialists in full for operations considered to be outside the scope of a general practitioner's skill.

Table 6. NUMBERS ENROLLED AND PERCENTAGE DISTRIBUTION OF ENROLLMENT UNDER "COMPREHENSIVE" CONTRACTS OFFERING SELECTED ITEMS OF SURGICAL CARE BENEFITS, BY ITEM OF SURGERY AND BY LENGTH OF WAITING PERIOD, NINE NON-PROFIT INSURANCE PLANS, DECEMBER 31, 1951

	Length of Waiting-Period in Months															
	0 Months		6 Months		9 Months		10 Months		12 Months		18 Months(b)		24 Months(b)		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Tonsillectomies and Adenoidectomies																
Enrollment	350,935	47.7	228,984	31.2	-	-	-	-	154,970	21.1	-	-	-	-	734,889	100.0
Contracts	5		3		-		-		5		-		-		13	
Herniotomies																
Enrollment	378,830(a)	51.5	228,984	31.2	-	-	-	-	127,075	17.3	-	-	-	-	734,889	100.0
Contracts	7		3		-	-	-		3		-		-		13	
Hysterectomies																
Enrollment	579,919	78.9	-	-	-	-	-	-	105,162	14.3	7,723	1.1	42,085	5.7	734,889	100.0
Contracts	8		-		-		-		2		1		2		13	
Obstetrical Surgery																
Enrollment	20,457	2.8	-	-	267,577	36.4	438,632	59.7	7,723	1.1	-	-	-	-	734,889	100.0
Contracts	2		-		5		5		1		-		-		13	
Other Female Surgery																
Enrollment	535,594	72.9	44,325	6.0	-	-	-	-	105,162	14.3	7,723	1.1	42,085	5.7	734,889	100.0
Contracts	7		1		-		-		2		1		2		13	

(a) Of these, 24,899 were enrolled under an "individual" contract with a 3 month waiting-period applicable to all surgery.
(b) It should be noted that 2 of the 3 contracts requiring waiting periods of 18 months or more enrolled their members on an individual rather than a group basis.

LIMITED INSURANCE

COVERAGE

Slightly more than one-half of the membership of non-profit plans in Canada[1] were enrolled for "limited" rather than comprehensive insurance in 1953, and of these, one-half were in the province of Quebec. Limited insurance programs for the most part offer "indemnification" rather than "service" benefits; in fact, non-profit indemnification plans, without doctor sponsorship, accounted for almost 92 percent of the limited insurance coverage. Insurance for surgical and obstetrical care was available to virtually all of these persons, while medical (non-surgical) care in hospital was also available to almost nine-tenths of them. However, in keeping with the general objective of limited plans to insure only those conditions which are non-recurring, uncertain, and expensive, physicians' services in home and office were not usually provided.

In 1951 about 6 percent of the Canadian population (varying from about 14 percent in Quebec to 1 percent in Manitoba, as shown in Table 7), were covered for limited medical services. By December 1953, this ratio has increased to over 8 percent. Of the 17 limited benefit contracts in effect at the end of 1953, 9 were offered by "indemnification" plans[2] covering 1,140,500 persons, and 8 by "service" plans covering 108,057 persons.

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(1) See p. 25 for U.S. data.

(2) Commercial insurance contracts are all of the limited, "indemnification" type. See footnote p. 17 for coverage under these contracts. The degree of duplication between the enrollment under commercial companies and non-profit plans is not available.

Table 7. ENROLLMENT UNDER "LIMITED" MEDICAL CARE CONTRACTS AS PERCENTAGE OF TOTAL POPULATION, BY PROVINCE, DECEMBER 1951 AND 1953.

Province	Percentage Enrolled					
	Surgical and Obstetrical Care Contracts		In-hospital Medical, Surgical & Obstetrical Care Contracts		Medical (non-Surgical) Care Contracts	
	1951	1953	1951	1953	1951	1953
Manitoba	1	2	1	2	-	-
Ontario	3	9	3	8	-	-
Quebec	14	15(a)	10	13(a)	0.04	0.06
Maritimes	7	9	6	8(a)	-	-
CANADA	6(b)	8(b)	5(b)	7(b)	-	-

(a) Estimates.
(b) Percentage of total Canadian population.

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5.54

The three plans having the greatest enrollment for limited medical benefits in 1952 were the Quebec Hospital Service Association, the Maritime Hospital Service Association, and the Associated Medical Services Incorporated (Ontario) plans, with 601,000, 152,000 and 106,000 members each. By the end of 1953, the new Ontario Hospital Association Blue Cross Plan for medical care[1] had become the second largest limited benefit plan in the country with over 200,000 members.

Two main types of limited contract are offered to members by these plans - one insuring against the costs of surgical and obstetrical care in home, office, and hospital, and one covering in addition, medical (non-surgical) care in hospital. However a third type of contract, which provides only medical (non-surgical) care in home, office, and hospital is offered by Les Services de Santé du Quebec. Enrollment under all surgical and obstetrical care contracts increased, as shown in Table 8, from 13,000 persons at the end of 1946 to 834,000 persons in 1951, and to 1,249,000 persons at the end of 1953. Of the 1953 enrollment, 88 percent, or nearly 1,094,000 persons, were also eligible for medical (non-surgical) care in hospital. When compared with the six-fold increase in comprehensive coverage over the

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(1) This plan introduced an indemnification in-hospital medical, surgical, and obstetrical care contract for its members in August 1952.

Table 8. NUMBERS OF PERSONS ENROLLED UNDER "LIMITED" MEDICAL CARE CONTRACTS, BY PROVINCE AND TYPE OF CONTRACT, NON-PROFIT INSURANCE PLANS, DECEMBER 31, 1946-1953.

Province - Contract	1946	1947	1948	1949	1950	1951	1952	1953
Manitoba								
Surgical & Obstetrical	8,502	8,965	8,526	8,653	10,342	8,321	11,551	12,379
In-hospital Medical, and Surg. & Obstet.	8,502	8,965	8,526	8,653	10,342	8,321	11,551	12,379
Ontario								
Surgical & Obstetrical	3,673	5,737	12,888	46,671	101,680	159,872	243,355	437,760
In-hospital Medical, and Surg. & Obstet.	1,515	2,552	7,295	38,413	86,753	135,873	194,261	377,381
Quebec								
Surgical & Obstetrical	865	165,342	259,926	366,733	478,743	554,152	611,488	639,000[b]
In-hospital Medical, and Surg. & Obstet.	865	97,739	168,341	262,085	330,358	407,111	534,186	564,000[b]
Medical Care only	90	555	660	940	1,369	1,642	1,818	2,433
Maritimes								
Surgical & Obstetrical	-	-	18,858	55,571	87,574	111,983	152,236	157,011
In-hospital Medical, and Surg. & Obstet.	-	-	15,515	43,673	70,711	94,621	134,771[b]	140,000[b]
CANADA								
Surgical & Obstetrical	13,040	180,044	300,198	477,628	678,339	834,328	1,018,630	1,248,564
In-hospital Medical,[a] and Surg. & Obstet.	10,882	109,256	199,677	352,824	498,164	645,926	874,769	1,093,760
Medical Care only	90	555	660	940	1,369	1,642	1,818	2,433
Annual Rate of Growth	66%	1275%	67%	59%	42%	23%	22%	23%

Source: Appendix II

(a) Enrollment under in-hospital medical, and surgical and obstetrical care contracts is included in the enrollment figures for surgical and obstetrical care.

(b) Estimated.

post-war period, it will be noted that a greater post-war expansion has occurred under the limited-benefit contracts where a 95-fold increase has taken place. This growth has been most striking in the province of Quebec, where comprehensive coverage is negligible;[1] limited coverage under non-profit plans in that province increased from 955 persons in 1946 to 556,000 persons in 1951, and to over 640,000 persons by the end of 1953. However, the annual rate of growth under limited insurance declined sharply from 1947 to 1951, and has remained fairly stable since that time at 22-23 percent. Chart 3 illustrates both the tremendous expansion in post-war coverage under limited contracts, and the decline in the rate of growth that has occurred in recent years.

The majority of persons covered for limited medical insurance purchase it from plans operating in the hospital insurance field as well. It is therefore possible to indicate, at least for somewhat more than half of all individuals purchasing any medical protection from non-profit plans, the number of persons with both medical and hospital protection under joint contracts. In 1953 for example, at least 92 percent (about 1,150,000) of the persons insured for some surgical protection under limited

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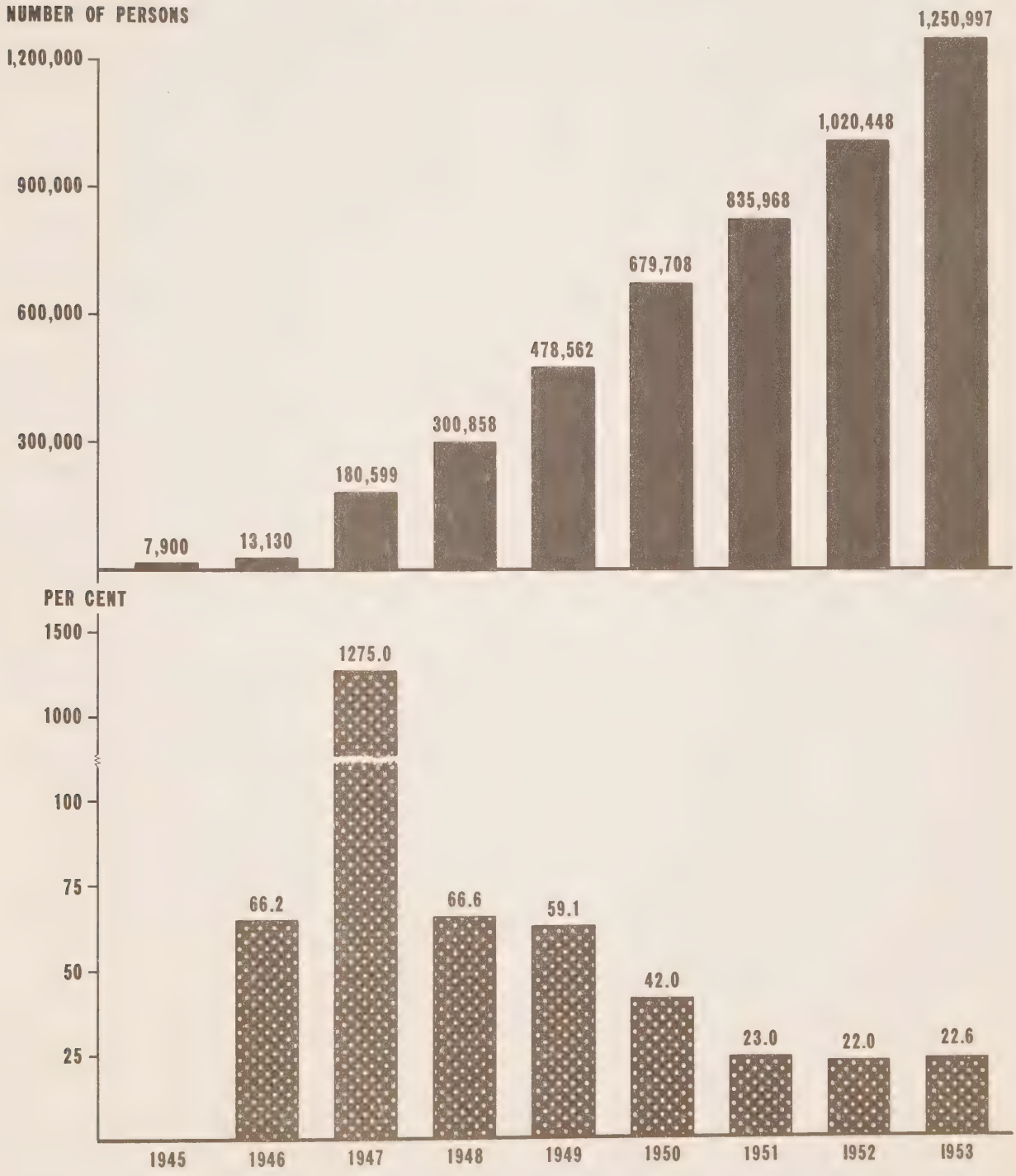
(1) It is believed that comprehensive contracts may be negotiated in Quebec province on a larger scale in 1954.

CHART 3

NUMBER OF PERSONS COVERED AND PERCENTAGE INCREASE IN ENROLLMENT OVER PREVIOUS YEAR, UNDER LIMITED MEDICAL INSURANCE CONTRACTS, 1945 - 1953



SOURCE: Table 8

insurance contracts, carried hospital insurance as well; those holding a wider range of benefits, including surgery, obstetrical and medical (non-surgical) services in hospital, and hospital insurance, accounted for about 82 percent of all persons insured for limited medical benefits. The latter group would represent over 7 percent of the total Canadian population and for these at least it can be said that they have acquired protection in some degree against the major costs of hospitalized illness. On the other hand, for the 1,105,000 persons with comprehensive medical insurance, no data are available concerning their purchase of voluntary hospital insurance, although no doubt a large number have done so. This information could be obtained only by conducting a large survey, specifically designed to yield information on family medical-hospital coverage purchased under joint contracts or through quite separate plans.

SCOPE OF BENEFITS

In most cases, limited medical care contracts exclude physicians' calls in home and office from the list of benefits available to their members. The benefits that are provided, including surgical and obstetrical services, medical (non-surgical) care in hospital, and x-ray, laboratory and other diagnostic services, are usually subject to dollar limitations, waiting-periods, or limits on the duration of treatment.

As previously mentioned, the material describing benefit provisions given in this section relates very largely to the benefits made available to the public at the end of 1951. The reader is cautioned, then, that some of the contractual limitations under the limited contracts discussed below may have been amended or eliminated by the end of 1953.

As noted earlier in this chapter, indemnification plans do not enter into contracts with doctors whereby the fees paid by the plans are accepted as full payment for services rendered. The attending physician is free then to set his fee in the usual manner. Since 92 percent of the persons insured under limited contracts were enrolled in indemnification plans in 1953, restrictions on general practitioner and specialist charges above the rates set forth in the plans' fee schedules could only apply to the

remaining 8 percent insured under the limited service plans. In fact, "extra-billing" by specialists was allowed under two of the five service plans offering limited contracts, which together covered over 70 percent of the persons enrolled for limited insurance with these five plans. It should be recognized that the indemnification approach to insuring sickness costs has a built-in "co-insurance factor" that roughly corresponds to the extra-billing provisions of the service plans in that the patient may be required to pay a portion of any charges incurred. For example in 1951, the Quebec Hospital Service Association plan estimates that it paid over 71 percent of the total surgical-medical bills of its members, the remainder being met by the members themselves.(1)

The nature of the various restrictions imposed by plans offering limited insurance illustrates some of the basic principles underlying the application of insurance techniques to the special field of sickness insurance. It is not considered sound insurance practice to attempt to insure against events that are almost certain to occur regularly or in the near future. Nor should the insurance protection increase the probability that the events insured against will in fact occur. Because it is thought that insurance coverage will increase the demands of insured

(1) E.D. Millican, "Report of the Executive Director", Quebec Hospital Service Association Ninth Annual Report, (Montreal, 1952).

persons for ordinary home and office calls, and because a certain number of such calls are almost sure to be required annually by each family, these benefits are not extended to persons enrolled under limited contracts.(1) In addition, deterrent payments by patients are required under one plan (C.M.S.F.) which includes in its contract a $15-deductible clause concerning payments for physicians' services(2). Similarly, liability for treatment costs for pre-existing conditions may be excluded or postponed, since such treatment is almost certain to be requested when it is made available. On the other hand, plans with comprehensive contracts, in accord with their policy of providing a broader range of benefits, can offer such benefits only by modifying their underwriting requirements, by negotiating reduced fee payments to participating doctors, or by charging premium rates(3) high enough to offset the additional costs involved.

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(1) For the same reason, drugs are not included in the benefits provided under either comprehensive or limited schemes; again, it is believed that insured persons are almost certain to request drugs, and in increasing volume, if their costs are insured.

(2) The AMS group contract formerly included a $25-deductible clause which was removed in 1948.

(3) It should be noted that, in many plans, monthly premiums are shared between employers and employees in order to make possible the extension of more comprehensive protection. See p. 183.

(1) Contractual Limitations

Apart from the more limited range of benefits offered, it should be noted that the same three contractual limitations which applied to comprehensive contracts apply also, and even more severely, to the limited contracts, together with an additional limitation on the duration of treatment provided.

(a) Surgery

Surgical and obstetrical care are the two benefits most commonly provided under limited contracts. Surgical benefits are available to virtually all[1] persons insured under such contracts, as Table 8 indicates. However, in 1951 maximum payments for surgical benefits were set at $150 or $200 per operation under five of the contracts covering 665,000 people, or 80 percent of all persons with limited insurance. An attempt to measure the effect of this limitation by comparing the actual fees paid by patients and the reimbursements allowed by the plans' schedules is given in Chapter IV.[2]

(b) Obstetrical Care

Obstetrical benefits, usually with dollar limits, are available to all persons under limited contracts who pay the family premium rates. In addition to the delivery

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(1) Except for some 2000 persons who were ineligible for any but minor surgery under one of these contracts.

(2) See p. 161.

itself, these benefits usually include pre- and post-natal care. Ninety per cent of the persons with limited insurance in 1951 (750,000) were enrolled in 7 contracts which set maximum maternity benefits at $50 or $60 per confinement. The remainder were insured with plans which pay general practitioner rates for confinements according to the provincial medical associations' fee schedules, Only one plan, with 8,000 members under limited insurance, paid obstetricians at specialist rates.

(c) Medical Services in Hospital

Medical (non-surgical) care in hospital[1] was available in 1951 to 77 percent of the members with limited insurance, of whom only seven percent (59,000 persons) were enrolled under service contracts. Under six of the nine contracts offering such benefits, this care was limited to a certain number of in-hospital attendances for each patient per admission or per year.[2]

(d) Consultant Services

In keeping with the general objective of limited plans to provide only a limited range of benefits,

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(1) Medical (non-surgical) care in or out of hospital was available to 1600 members of SSQ which permitted specialists and general practitioners to extra-bill only those members who were in the upper-income groups.

(2) MHSA and QHSA allowed $3.00 per day for 31 days for each admission, two MMS contracts allowed one call per day for 31 days per year, SSQ allowed 42 calls, and PSI allowed 51 calls per person per year.

consultant services, upon referral, were not made available to 78 percent (656,000 persons) of the limited-contract enrollees in 1951. Limited services were provided for 19 percent (157,000 persons) and unrestricted consultant services for only 3 percent (23,000 persons) of the members enrolled under limited insurance contracts. Maximum payments for the limited consultations were set at $5 and $10, or 50 percent of the scheduled rate. Under three contracts, the consultations themselves were limited to in-hospital consultations only, or one per hospital admission, or one medical and one surgical per year.

(e) Laboratory and X-Ray Services

Laboratory and other diagnostic services are ordinarily provided by hospitals as part of the ancillary services extended to hospitalized patients. Over 86 percent of the persons insured under limited medical contracts (722,368) in 1951 were also insured under hospital contracts which included these benefits in the general hospital care available to their subscribers. However, one indemnification plan which provided both medical and hospital benefits, extended laboratory and other diagnostic services to its 96,000 members (11.5 percent) under its medical care contracts.(1) As for the remaining two percent (17,600 persons), 9300 were eligible for these benefits only in

(1) These benefits, available only for hospitalized conditions, were paid at the rates set forth in the plan's fee schedules.

surgical and obstetrical cases, while the other 8,300 were not eligible for such benefits at all.

Similarly, although almost 80 percent of limited contract holders (665,000 persons) were not entitled to any x-ray services under their medical contracts in 1951, they were covered for such services under their hospital insurance contracts. On the other hand, 19 percent, or 162,000 persons, could obtain limited diagnostic x-rays under medical contracts.(1) The full cost of x-rays in fracture cases was provided for 18 percent of the insured persons (152,000), and limited x-rays for fractures were available to the remaining 2 percent (19,000 persons). The four contracts which limited x-ray services for fractures set limits of $15, $25, $35, and 50 percent of the scheduled rates up to $50 per person per year on all x-ray services. Other contracts limited payments for diagnostic x-rays to $35 per person per year, or restricted such services to in-hospital x-rays only.

(f) All Medical Care

Although payments on the basis of a fee schedule naturally limit the expenditures by a plan on particular items of benefit, no limitations were imposed on total indemnification for medical care expenditures for 87 percent

(1) The remaining 8,300 persons were not entitled to any x-rays for diagnostic purposes, other than for suspected fractures.

of limited contract members in 1951. Reimbursement for total medical care expenditures in any one year was limited under only four contracts,(1) covering 111,000 people, to $500, $800, $900 and $1600 per member.

(2) Waiting Periods

To insure that at any one time the number of members will be greater than the number of benefit recipients, most plans offering limited contracts combine strenuous efforts to expand enrollment every year with the stipulation that newly-enrolled members must undergo waiting periods(2) before they become eligible for those services required for treatment of pre-existing conditions or for certain surgical procedures such as tonsillectomies and herniotomies. Reimbursement for the costs of obstetrical care and of treatment for pre-existing conditions are the two benefits most commonly subjected to such waiting-periods under limited insurance plans. However, the QHSA and MHSA plans may waive all waiting-periods for those groups which include more than 50 subscribers and/or where the employer pays part of the premium, provided at least 75 percent of the establishment has been enrolled.

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(1) A waiting period of 2 months before any benefits could be claimed was required in 3 of these contracts; the other required members to pay the first $15 for any professional services received.

(2) The waiting-periods discussed here do not include any time-lag required by some plans between the date the first premium is paid and the date the contract comes into effect.

Maternity benefits in 1951 were extended after a nine-month waiting period to 80 percent of the limited-contract holders (667,000 persons), and after a 10-month wait to another 18 percent (152,000). The remaining 2 percent (16,000) were required to wait 12 months from the date of enrollment before confinements were covered.

The majority of these members, 66 percent or 551,000 persons, were covered for the costs of treatment for pre-existing conditions, after a period of 12 months of membership.(1) Twelve thousand had to undergo a ten-month waiting period. However, no wait at all was required of 16 percent (133,000) of the insured persons. As in the case of comprehensive insurance, plans offering limited insurance on a non-group basis, together with one other plan writing both group and non-group insurance, completely excluded insurance against pre-existing conditions from the benefits available to their 140,000 members (17 percent).

Surgical benefits, the major benefits offered by limited insurance schemes, may involve high cost claims, and are therefore limited to the amounts set forth in each plan's fee schedule for the various items of surgical care.(2) In addition to these maximum payments, individual

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(1) Unlike comprehensive insurance where about the same proportion of members were eligible for such treatment as soon as they enrolled.

(2) See p. 162.

waiting periods are assigned to a few types of surgical operation and procedure. Most of the persons enrolled under limited benefit contracts were eligible for hysterectomies and other female surgery without undergoing any waiting period whatsoever, and for tonsillectomies and herniotomies after a lapse of six months. Obstetrical surgery usually required 9 months of membership before it was included in the benefits available. The varying waiting periods enforced in 1951 for these items of surgery, and the total enrollment in each case, are summarized in Table 9. The importance of this limitation is best measured in terms of the members ineligible for benefits at any one time, but these data are not available.

Table 9. NUMBERS ENROLLED AND PERCENTAGE DISTRIBUTION OF ENROLLMENT UNDER "LIMITED" CONTRACTS OFFERING SELECTED ITEMS OF SURGICAL CARE BENEFITS, BY ITEM OF SURGERY AND BY LENGTH OF WAITING PERIOD, EIGHT NON-PROFIT INSURANCE PLANS, DECEMBER 31, 1951

Item of Surgery		Length of Waiting Period in Months														Total	
		0 Months		6 Months		9 Months		10 Months		12 Months		18 Months		24 Months		Excluded			
		Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Tonsillectomies and Adenoidectomies	Enrollment	123,787	14.8	675,256	80.8	-	-	1,161	0.1	35,766	4.3	-	-	-	-	-	-	835,970	100.0
	Contracts	3		8		-		1		4		-		-		-		16	
Herniotomies	Enrollment	135,873	16.3	673,614	80.6	-	-	1,161	0.1	23,680	2.8	-	-	-	-	1,642	0.2	835,970	100.0
	Contracts	4		7		-		1		3		-		-		1		16	
Hysterectomies	Enrollment	826,007	98.8	-	-	-	-	-	-	7,192	0.9	1,129	0.1			1,642	0.2	835,970	100.0
	Contracts	13		-		-		-		1		1				1		16	
Obstetrical Surgery	Enrollment	-	-	-	-	665,460	79.6	152,380	18.2	16,488	2.0	-	-	-	-	1,642	0.2	835,970	100.0
	Contracts	-		-		5		8		2		-		-		1(a)		16	
Other Female Surgery	Enrollment	781,367	93.5	675	0.1	-	-	1,161	0.1	22,561	2.7	1,129	0.1	27,445	3.3	1,642	0.2	835,970	100.0
	Contracts	8		1		-		1		2		1		2		1		16	

(a) Minor Surgery only.

MEMBERSHIP REQUIREMENTS

GROUP AND INDIVIDUAL ENROLLMENT

A basic insurance principle, applicable to all fields of insurance, is the requirement that there should be a large number of policyholders representative of the whole population, both good risks and bad. The larger the membership, the better able a plan is to achieve a normal distribution of risks, and to spread its costs, thus keeping premiums as low as possible.

Various approaches have been adopted by the non-profit plans to the problem of enrollment. As previously noted in Chapter I,(1) the first plan to offer prepaid medical care on a non-profit basis began by enrolling individuals under a contract offering a comprehensive range of benefits. Since that time, only three other plans had by 1952 developed contracts which enroll new members on a non-group basis - one beginning in 1946, one in 1950, and the third in 1951.

The great majority of the insured persons are enrolled under group contracts, usually on the basis of employment, although a few of the plans write contracts with rural municipalities, credit unions, producers' co-operative associations, service clubs, and so on. Only employed groups were able to enroll

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(1) See p.3.

under 16 of the 30 medical care contracts, covering over 80 percent (1,269,000 persons) of the insured population in 1951. Eleven contracts required at least 75 percent of all eligible employees in a firm to be enrolled before the group was accepted for benefits. This provision was usually worded "a minimum of ten persons[1] or 75 percent of the payroll, whichever is larger".

Alternatively, four of the plans required 100 percent enrollment in firms with only ten[2] employees, gradually diminishing this proportion as the size of the firm increased, to a minimum requirement of 50 or 60 percent when there were over 100 or 200 employees. The Manitoba plan would enroll groups of eight employees or more, and the Maritime Medical plan groups of at least ten persons with the same employer or in the same society. Finally, the Services de Santé plan would enroll members of credit unions,[3] with the stipulation that each group contain at least 25 subscribers, and that an average of 2.5 persons be covered under each subscriber's contract.

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(1) The Physicians' Services "Green" contract, the Windsor and Maritime Medical, "Surgical and Obstetrical" contracts, required only five employees, while the Saskatoon "B" contract required a minimum of 75 employees.

(2) Six in the case of the Ontario Blue Cross medical contract.

(3) The Ontario Cooperatives and the Alberta plan also enroll credit union members.

Three plans write group contracts with rural municipalities, which covered an estimated 60,000 residents in 1951. The largest of these, the Maritime Hospital Service plan, enrolled about one-third of its total membership or 37,000 persons in community or school district groups, requiring a minimum participation of 50 percent of the ratepayers in a district. Premium rates for these groups were somewhat higher than for employed groups. The Saskatoon plan enrolled 8,500 persons in 1951 in a special Community contract which required a minimum of 75 residents or 80 percent of the community. And finally, the Regina plan had a special arrangement with eight rural municipalities whereby referred medical services only were provided by the plan to 14,500 local residents in 1951.

Self-employed persons and independent workers can enroll in non-profit medical care schemes on an individual basis in seven provinces where non-group contracts are available to new subscribers who are not eligible for group enrollment. The Saskatoon, Manitoba, and Associated Medical (Ontario) plans write non-group contracts whereby eligible persons who are not members of employed groups may enroll individually by paying somewhat higher premiums. In 1951, a total of 61,200[1] persons were enrolled under these

(1) The Maritime Hospital Service Association since July 1951 has also offered a non-group contract, but information about this plan was not available. It is of interest to note that 53 out of 70 U.S. Blue Shield plans in 1951 offered non-group contracts, and that a total of 2 million persons were covered under non-group hospital or medical care contracts in that year.

non-group contracts, of which 32,600 were entitled to comprehensive benefits, and 28,600 were eligible for limited benefits. All but 1,100 of the latter were enrolled under one indemnification plan. These contracts usually have more stringent waiting-periods, age restrictions, and health qualifications than have group contracts.

Apart from these non-group contracts, most of the plans write special contracts with former members of employed groups who leave such employment, allowing them to continue their membership in the plan at higher rates. Members of most plans, on moving to another province, are able to transfer their membership to a non-profit plan operating in that province through the Inter-Plan Transfer Agreement of Trans-Canada Medical Plans,(1) or through the Canadian Council of Blue Cross Plans which has a similar arrangement. Both these organizations also plan to make it possible for establishments with employees in several provinces to insure them under a common contract through autonomous plans in each province.

To determine, if only in a very general way, the extent to which the voluntary non-profit plans have been successful in enrolling groups of employees under their group contracts, two approaches may be adopted. The crude approach is simply to compare the estimated number of

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(1) See pp. 9 and 175-178.

subscribers to such contracts (excluding dependents), with what might be considered the potentially[1] eligible population - the total labour force, excluding managerial and self-employed persons, and professional and agricultural workers. It may be noted from Table 10 that about 16[2] percent of the Canadian labour force so defined was enrolled on December 31, 1951. Manitoba had the highest percentage enrollment, 23 percent, while Alberta, with the same size "labour force" as Manitoba, had the lowest enrollment, 7 percent. Since this measure of the labour force includes many workers in establishments too small to qualify for group enrollment under most of the plans, a more valid comparison may be made by considering estimated group enrollment in relation to the total number of non-agricultural wage-earners in establishments employing 15 or more persons. This measure of the labour force includes salaried executive employees who were excluded from the first measurement. Twenty-four[2] percent of all such wage-earners in Canada were enrolled under employed group contracts in 1951, ranging from 34 percent in Manitoba to 12 percent in Alberta. The Maritime enrollment figure is overestimated, however,

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(1) Potential eligibility is here considered only in relation to employment, with no regard to age, health, or other qualifications which might also affect eligibility.

(2) Compare this percentage with the proportion (11 percent) of the total Canadian population covered, as shown on p. 19.

for it includes an unknown number of persons enrolled in social or community groups who are not included in this measure of the labour force. Further, all these percentages are somewhat inflated, since many plans enroll groups of 5 or 10 employees. Only 3 contracts require a minimum of 15 or more employees. The two percentage columns in Table 10 can be taken as representing the upper and lower limits between which lie the actual percentages of the potentially eligible employee population enrolled.

AGE LIMITS

Since elderly persons are considered to be poor insurance risks, because of their patterns of illness and the nature of the medical services they require, membership under the non-profit plans has to date largely been limited to the working population and their dependents. For adults, the factor of employment tends to exclude older people without previous coverage in the seven plans(1) which in 1951 would enroll only employed groups. In addition to this automatic control on eligibility for membership, some of the group contracts had established specific age limits

(1) Including the B.C., Alberta, Regina and Windsor plans, and Physicians' Services, Ontario Blue Cross, and Quebec Blue Cross. The group contracts offered by the Manitoba plan and the Associated Medical Services were similar in this respect. It should be noted that, with the exception of the Regina plan, no specific age ceilings applied to these plans.

Table 10. ESTIMATED NUMBERS OF SUBSCRIBERS IN EMPLOYED GROUPS IN TWELVE NON-PROFIT MEDICAL INSURANCE PLANS, AS PERCENTAGE OF LABOUR FORCE[a], AND OF NON-AGRICULTURAL WAGE-EARNERS IN ESTABLISHMENTS WITH 15 OR MORE EMPLOYEES[b], BY PROVINCE, 1951

Province	Estimated Subscribers in Employed Groups[c]	Per Cent of Labour Force[a]	Per Cent of Non-Agricultural Wage-Earners[b]
British Columbia	74,751[d]	21.8	32.9
Alberta	13,329[d]	7.1	11.7
Saskatchewan	13,200	11.4	23.6
Manitoba	42,500	23.0	33.8
Ontario	165,800	12.0	16.1
Quebec	220,000	20.8	31.0
Atlantic Provinces	55,000	13.9	26.8
Canada	584,580	15.9	23.7

(a) Wage-earners and salaried employees 14 years of age and over, excluding agricultural and professional employees, and proprietory and managerial personnel, from D.B.S. Ninth Census of Canada, Volume IV, Table 10, 1952.
(b) Employees in the major non-agricultural industries in establishments having 15 or more employees, from D.B.S. Annual Review of Employment and Payrolls 1951. Table B, p. 4.
(c) Accurate data are not available on the numbers of subscribers (excluding dependents) enrolled in employed groups.
(d) Actual number of subscribers.

as well.(1) Four other plans, including the Ontario Co-operatives, the Maritime Hospital Plan, Saskatoon's "Community" contract and Maritime Medical Care's "M.S.O." contract accepted adult applicants of any age who were not required to be members of employed groups, but might enroll under other types of group contracts. Further, members of most of these plans could continue membership indefinitely, usually at somewhat higher rates,(2) upon leaving employment or upon retirement, after a minimum period of coverage varying from three months to 10 years.

Most of the six plans which offered contracts setting definite age ceilings on new membership in 1951, also made some provision for continued insurance in advanced age. Such entrance-age ceiling varied from 55 years under Associated Medical's "1600" and "900" contracts to 70 years under the Services de Santé Plan. Under the non-group contracts offered by the Maritime Hospital Service and the Saskatoon plan this limit was 65 years, while membership under Manitoba Manitoba's non-group contracts ceased at age 64 years. However, coverage beyond age 65 years was extended to members of the Saskatoon plan, and beyond age 55 years to members of

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(1) The Regina plan and Saskatoon's "A" contract would not enroll new members who were 65 years of age or older.

(2) In addition, under the Alberta plan, an extra charge of 40¢ per month is required from each person over 65 years of age, except that each member is granted coverage after 65 years at the regular rate for a period equivalent to that during which he was continuously enrolled before reaching this age.

the Associated Medical Services plan, for a period equivalent to each member's enrollment before attaining this age.(1)

All of the plans are designed to provide insurance protection to subscribers and their families, including dependent children, usually from birth to the age of 18 or 19 years.(2) Most of the contracts, covering 81 percent of the insured population in 1951, included dependent children from birth. However, six plans offered contracts with a minimum age requirement varying from two months under Associated Medical's "1600" and "900" contracts to 6 months under Saskatoon's "Individual" and "A Group" contracts. The B.C., Regina, Manitoba "Non-group", and Services de Santé contracts set the minimum age limit for membership at 3 months. All of the plans set upper age limits to the eligibility of dependent(3) children for coverage under family contracts.

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(1) It should be noted that those group contracts which limit membership by age as well as by employment - see footnote (1) page 69 - also granted such extended coverage to members who had reached the age limit.

(2) Three plans include dependent adults under family contracts. "Sponsored subscribers" under the Manitoba plan must be unemployed, under 65 years of age, and more than 50 percent dependent on the subscriber. Adult relatives of subscribers to Windsor's comprehensive contract between the ages of 21 and 60 years at the time of enrollment must be wholly dependent on the subscriber. Dependents (as defined by the Income Tax Act) regardless of age, may be covered under the Alberta plan.

(3) Dependent children must be unmarried, and must not earn more than $10 and $7 per week under the Saskatoon and Windsor plans respectively. Children who cease to qualify as "dependents" may purchase insurance in their own right.

Eight of the plans, with 40 percent of total membership in 1951, covered subscribers' children until the age of 18 years. Five others, covering 53 percent, set the limit at 19 years. Associated Medical Services would enroll only those children who were under 17 years, while the Saskatoon "Community" contract covered dependent children until they reached 21 years of age.

PROOF OF GOOD HEALTH

The majority of the plans operating in Canada do not require new members to provide evidence of good health or submit to a medical examination. In 1951, only three plans - the Regina plan, the Saskatoon "Individual" contract, and the Associated Medical Services "1600" and "900" non-group contracts - required each applicant to complete a medical questionnaire, outlining the general condition of his health and his past sickness experience. In addition to these, persons who enrolled in the British Columbia, Alberta, or Saskatoon plans later than one month from the date at which they first became eligible for membership had to submit evidence of good health. If they enrolled within the month, however, no such evidence was required. Although no medical examination was required of Manitoba members, any pre-existing conditions had to be listed on their application forms; the applicants were expected to be "in reasonably good health", as were applicants for MHSA's non-group contracts. Similarly, children of employees enrolled in the

Associated Medical "Group" contract were covered for benefits "providing they are in good health", although no medical examination was required of the employees themselves. The remaining eight plans, covering 68 percent of the 1951 insured population, had no health requirements, although four of them enforced waiting periods before pre-existing conditions were covered, as mentioned in an earlier section.(1)

INCOME LIMITS

None of the Canadian plans restrict membership on the basis of an individual applicant's income. However, the British Columbia plan which emphasizes group enrollment and group "experience-rating",(2) approaches the question of income limits from the viewpoint of group income. High income recipients are barred from membership only when more than ten percent of an employed group earn more than the average B.C. industrial wage. At one time, the Manitoba plan did withhold membership under its group contracts from single persons, married couples, and families earning more than $1800, $2,400 and $3,000 respectively. This restriction was withdrawn in March, 1950, and is no longer in effect.

Although membership in the plans is not dependent on incomes, it has already been noted that benefits under two of

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(1) See p. 41.
(2) See p. 89.

the plans are limited for high income groups.(1) In general, in place of income limits, the Canadian plans have adopted the approach that specialists (and also general practitioners in the case of indemnification plans) should be free of charge their usual fees to member patients. It is of interest to note that the only plan which completely prohibits such extra-billing by specialists originally did impose income limits on membership.

(1) See pp. 36-37.

III - FINANCES

REVENUE AND EXPENDITURE

The non-profit plans in Canada spent $20.7 million on medical benefits for their members in 1952, or $11.85 per person. Of this amount, the service plans paid out $15 million or $16.70 per member, and the indemnification plans which, as noted previously, are limited insurance schemes, spent $5.7 million or $6.75 per capita. The corresponding figures for 1953 are estimated to be $27 million or $12.55 for all plans, including $19 million or $17.45 per capita for service plans, and $8 million or $7.35 for indemnification plans. In keeping with the general post-war increase in enrollment discussed in the previous chapter, revenues and expenditures have been steadily mounting since 1945, and have considerably more than doubled between 1949 and 1952 as shown in Table 11. Since 1949, members' premium payments increased from $9½ to $24 million, while expenditure on benefits rose from $8 to $21 million.

On the average, the medical insurance plans receive more than 99 percent of their revenue in the form of subscribers' premiums and spend over 80 percent of it on benefits, and about 10 percent on administration, as illustrated in Chart 4. The remainder is assigned to stabilization accounts or other reserves established for the protection of the plans against adverse claims experience or other

contingencies. No dividends of any kind are paid to subscribers or shareholders, although benefits may be increased following continuously successful operations.

However, considerable variation occurs in the actual financial experiences of the different medical insurance plans. In the last chapter it was emphasized that comparisons between different plans are almost impossible to make, owing to the great diversity in the nature of the benefits offered by each plan, and in the types of plans themselves. Since service plans guarantee to pay the complete cost of general practitioner care and certain additional benefits, it is natural to expect the per capita costs of benefits offered by these plans to be considerably higher than those of "indemnification" plans. Similarly, the contracts written may offer a comprehensive or a limited range of benefits accompanied by certain waiting-periods, dollar limitations, or other exclusions. Contracts which provide both medical and hospital benefits may be expected to have higher administrative costs, as may contracts which are open to individual subscribers. Moreover, the cost to the plans of the various benefits offered will vary from one province to the next, since there is considerable variation among the physicians' fee schedules prevailing in each province. And finally, each plan may have a different financial policy, requiring different amounts in reserve funds, and meeting physicians' claims in one of a variety of ways. In the

material that follows, it must not be inferred that comparisons between the operating experiences of the various plans are being made when the per capita costs of all benefits or of particular items of service are presented for several plans. The above limitations seriously impair the validity of any such comparisons.

With regard to revenues, other than the premium payments by or on behalf of their members, the plans' only sources of revenue are interest on their reserves, and, in the case of five plans, registration fees or membership deposits when members first enroll. The average annual premium per participant in the medical insurance plans was about $13.55 in 1952, as Table 11 indicates, with the purely medical care plans receiving an estimated $19.30 per member, and the joint medical-hospital care plans receiving approximately $8.00 per member on medical contracts. By 1953 it is estimated that these averages increased to $14.60 for all plans, $20.35 for purely medical care plans, and $9.00 for joint plans. It may be noted from Appendix IV that, among the eight plans offering medical care contracts only, estimated per capita premium receipts in 1952 ranged between $24 under the B.C. plan and $15.30 under the Regina plan, while Windsor's receipts were nearest the average for the eight plans. Premium receipts from medical contracts

Table 11. TOTAL AMOUNTS, PERCENTAGE DISTRIBUTION, AND PER CAPITA AMOUNTS, OF REVENUES AND EXPENDITURES OF NON-PROFIT MEDICAL INSURANCE PLANS, 1949-1952

	1949[a]			1950			1951			1952		
	Total	Per Cent	Per[b] Capita	Total	Per Cent	Per[c] Capita	Total	Per Cent	Per[d] Capita	Total	Per Cent	Per[e] Capita
	$		$	$		$	$		$	$		$
Revenues												
Premiums[f]	9,506,981	99.6	12.57	12,783,636	99.5	12.21	18,082,107	99.5	12.76	23,734,200	99.3	13.55
Interest, etc[g]	42,639	0.4	.06	62,448	0.5	.06	96,486	0.5	.07	170,221	0.7	.10
Total	9,549,620	100.0	12.63	12,846,084	100.0	12.27	18,178,593	100.0	12.83	23,904,421	100.0	13.65
Expenditures												
Benefits	7,819,641	81.9	10.34	10,540,971	82.1	10.07	15,595,419	85.8	11.01	20,733,749	86.7	11.85
Administration[g]	1,034,380	10.8	1.37	1,354,494	10.5	1.29	1,815,814	10.0	1.28	2,237,920	9.4	1.25
Total	8,854,021	92.7	11.71	11,895,465	92.6	11.36	17,411,233	95.8	12.29	22,971,669	96.1	13.10
Net Operating Surplus	695,599	7.3	.92	950,619	7.4	.91	767,360	4.2	.54	932,752	3.9	.55

Source: Appendix IV.

(a) Data for M.M.C. not included.
(b) Based on average enrollment of 756,127.
(c) " " " " " 1,046,558.
(d) " " " " " 1,416,798.
(e) Based on an estimated average enrollment of 1,749,974.
(f) A.M.S. and Q.H.S.A. premiums for medical care estimated from proportion of benefit expenditures going for medical care.
(g) A.M.S., Q.H.S.A., S.S.Q., C.M.S.F. and O.H.A. administration and interest applicable to medical care contracts estimated as in (f). M.M.C. estimated for 1950.

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offered by the six[1] joint medical-hospital benefit plans in the same year ranged between an estimated $7.15 per capita under the Quebec Blue Cross plan and $10.45 under the Services de Santé plan, with all but the former considerably above the average of $8.00 for this group.

The estimated average per capita expenditure on medical benefits in 1952 was about $17.00 in the purely medical care plans, ranging from $12.85 in the Alberta plan to $22.30 in the B.C. plan; in the joint medical-hospital care plans, the estimated average was $6.80, ranging from approximately $6.35 in the Quebec Blue Cross plan to about $8.45 in the Services de Santé and Maritime Blue Cross plans. The 1953 averages are estimated to be $17.80 and $7.40 under the medical and joint plans respectively.

The fluctuations in the size of the annual net operating surplus of each plan, as shown in Appendix IV, indicate the need for some type of stabilization account or reserve to cushion the shock of an exceptionally large number of claims in any year. In most of the provinces, insurance regulations require the plans to maintain certain reserves to be used in the event of adverse claims experience. Over the period 1949 to 1952, the estimated per

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(1) It was not possible to estimate O.H.A's per capita premium receipts for the four months during which this plan offered medical contracts in 1952. In 1953 it is estimated that over $10.00 per capita was received in medical care premiums.

capita surplus on the operations of all plans steadily diminished from 92 cents to 55 cents as shown in Table 11. However, these averages include estimated surpluses on the medical contracts of the joint medical-hospital benefit plans, which in many cases are difficult to allocate between medical and hospital benefits.(1) Among those plans which offer medical benefits only, aggregate surpluses of $450,000, $714,000, $624,000 and $674,000 were experienced in 1949, 1950, 1951, and 1952 respectively. These figures obscure the fact that one or two individual plans suffered deficits in each of these years. It must also be borne in mind that most of the plans do not pay claims in full, but discount their payments to participating doctors either at a fixed rate, or according to the sums available for distribution. Were these claims paid at 100 percent of the fee schedules concerned in 1951 for example, the surplus would have been eliminated, and a deficit of $1.1 million would have been experienced by the eight purely medical insurance plans.

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(1) The Maritime Hospital plan has made such an allocation for the year 1950, when it paid out 71 percent of its medical contract premium receipts on claims and 18 percent on administration, with a surplus of 11 percent, or $1.23 per capita.

REVENUES

PREMIUMS

It was noted above that 99 percent of the voluntary plans' revenue comes from premiums from (or on behalf of) their members. The premiums which subscribers pay vary according to their marital status or family size, and the type of contract under which they are enrolled. The monthly premium rates charged by each of the non-profit plans in 1948 and 1952 are given in Appendix V.

The average premium rates charged under group contracts offering comprehensive benefits in 1952 were approximately double the average group rates charged under limited contracts. Families paid an average monthly rate of $5.65 for comprehensive insurance, as shown in Table 12, and $2.70 and $2.78 for limited medical benefits in hospital, surgical, and obstetrical care under service and indemnification contracts respectively. Similarly, single persons paid $2.02 monthly for comprehensive benefits, and $1.00 and 94 cents for limited insurance under service and indemnification plans.

In the post-war period premiums have risen steadily to keep pace with the increasing prices of medical care, labour, equipment, and other administrative items, and the increased utilization of insurance benefits. Only in two

Table 12. LOW, HIGH, AND AVERAGE MONTHLY PREMIUM RATES UNDER GROUP CONTRACTS, BY TYPE OF CONTRACT AND FAMILY SIZE, THIRTEEN NON-PROFIT MEDICAL INSURANCE PLANS, 1952

	MONTHLY PREMIUM RATES FOR								
	Single Persons			Married Couples			Families		
	Low	High	Average[a]	Low	High	Average[a]	Low	High	Average[a]
Service Plans									
Comprehensive	1.66	2.60	2.02	3.33	7.80	4.35	4.00[b]	7.80	5.65
Limited									
In-hosp. Medical Surgical and Obstetrical	.75	1.25	1.00	2.00	2.50	2.25	2.00	3.10	2.70
Surgical and Obstetrical	.75	1.35	.94	1.75	2.25	1.92	2.25	2.50	2.42
Indemnification Plans									
In-hosp. Medical Surgical and Obstetrical	.70	1.10	.94	1.65	3.00	2.59	2.40	3.00	2.78
Surgical and Obstetrical	.60	1.25	.90	1.75	2.50	2.08	1.75	2.50	2.08

Source: Appendix IV.

(a) These averages are simply the means of the group rates charged under each contract in the five categories listed. Non-group rates are not included.
(b) The combined rate for contracts A and B under Les Services de Santé du Québec.

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plans have rate increases been accompanied by expanded benefits.(1) The percentage increases between 1948 and 1952 are shown in Appendix V. The largest increase in family rates for comprehensive insurance occurred under the B.C. plan, amounting to 78 percent, and the smallest increase was one of 9.5 percent under the Maritime Medical plan. The rates for single persons increased between 1948 and 1952 by 80.6 percent under the B.C. plan, 46.7 percent under the Maritime plan, and only 23.3 percent under the Physicians' Services (Ontario) plan. In the case of limited insurance contracts offered by service plans, there was no increase at all under four of the five plans, while single rates increased by 108.3 percent and family rates by 71.4 percent under Manitoba's group contract.

The indemnification plans, which agree to pay fixed sums toward the cost of medical care, had less need to increase their rates during this period of rising prices. Such rate increases would be necessitated only by expanded benefits or by an increased volume of claims per member. Only the Maritime Hospital plan increased its rates (by a small percentage) between 1948 and 1952. However, it should be added that, without changing its rates, the AMS plan

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(1) Regina and Manitoba both reduced waiting periods, and the former increased auxiliary benefits as well. The AMS plan increased the medical benefits available under its group contract during this period by removing $25 - and 2-day-deductible clauses, and adding out-of-hospital fractures and surgery, without changing its premium rates.

reduced the medical benefits provided to its non-group members and at the same time increased the hospital benefits available. Home and office calls were removed from the list of benefits offered its subscribers, through the replacement of the "800" service plan with the "1600" plan (with increased hospital benefits) or "900" plan (without hospital benefits) both of which are indemnification contracts.

(1) Actuarial Basis of Premiums

(a) Family Structure

The premium structure of each plan is related to the proportions of single persons, married couples, and families that are expected to be found among its membership, and to the anticipated per capita costs of providing benefits to these persons. Six plans have rate structures with only two levels - one rate for single persons, and another for families. Five plans have three-level rate structures, the additional rate applying to married couples without children. The remaining three plans[1] have multiple-level rate structures with rates increasing as family size increases. The actual rates are shown in Appendix V. If the average "monthly premium return" (i.e., the per capita amount required to meet total costs if all persons were assessed a flat premium rate) is compared with the actual monthly premium rates, expressed on a per capita basis, it is

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(1) Each of these plans, however, offers contracts with two or three level structures.

interesting to note that, in most cases, families of four or more persons are paying less per person than the average premium return required, while single persons and small families are paying more. For example, Table 13 illustrates the shift in the per capita rates from large families to small in four comprehensive plans in 1951. The plan with a two-level structure placed a heavier burden on married couples without children than on any other category - $1.65 per person more than the average monthly cost of any individual to the plan. The plan with a five-level structure charged small families per capita rates which conformed much more closely to the per capita premium return for the whole plan. In one of the plans with a three-level rate structure, single persons and married couples had their premium rates loaded by an additional 46 cents; in the other, the rates for single persons and three-person families were both loaded by 39 cents, somewhat less than the loading for married couples (52 cents) without dependents. However, the average family size may vary considerably from one plan to another. Therefore, the degree of loading may be quite heavy for a particular family category but not seriously affect the majority of a plan's members.

Table 13. MONTHLY PER CAPITA PREMIUM RETURN, PER CAPITA PREMIUM RATES, AND EXCESS OF RATES OVER RETURN, BY FAMILY SIZE, FOUR COMPREHENSIVE SERVICE PLANS, 1951

Plan	Monthly Per Capita Premium Return	Monthly Per Capita Premium Rates for							
		Single Persons		Married Couples		Three person Families		Four person Families	
		Rate	Amount Over Premium Return	Rate	Amount Over Premium Return	Rate	Amount Over Premium Return	Rate	Amount Under Premium Return
	$	$	$	$	$	$	$	$	$
M.S.A. - B.C.(a)	1.75	2.30	.55	3.40	1.65	2.27	.52	1.70	.05
M.S.I. - Alberta(b)	1.36	1.75	.39	1.88	.52	1.75	.39	1.31	.05
G.M.S. - Regina(b)	1.29	1.75	.46	1.75	.46	1.42	.13	1.06	.23
W.M.S. - Windsor(c)	1.58	1.85	.27	1.85	.27	1.67	.09	1.52	.06

Sources: Appendices IV and V.

(a) Plan has a two-level rate structure.
(b) Plans have three-level rate structure.
(c) Plan has a five-level rate structure.

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It must not be inferred that the full cost of the insurance rates as shown in Appendix V are borne in all cases by the subscriber. In many of the group contracts written with employed groups, the employer bears a considerable portion of the contribution rate. In fact, in the British Columbia plan, under which the employer is contractually liable for payment of premiums on behalf of his enrolled employees, most groups practise a 50-50 division of the premium and the registration fee between the employer and his employees. As mentioned in the final chapter,(1) over 70 percent of the manufacturing establishments in Canada with some form of prepaid sickness benefit plan for their workers in April 1953 paid a portion of the premiums for those workers who were insured.(2)

No enrollment fees are required of persons wishing to join nine of the plans. But five plans require new applicants to pay certain registration fees or membership deposits. These fees amount to $1.50 per subscriber in the case of the British Columbia and Alberta plans, $5.00 per adult under Saskatoon's "A" contract, and $1.00 per adult under Saskatoon's "B" and "Community" contracts, and the Regina plan. A refundable deposit of $1.00 per subscriber is required under the Services de Santé plan.

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(1) See p.183.

(2) In the United States, a limited 1950 survey showed that of the employed groups covered under 46 limited insurance plans reporting, an average of 42 percent had some employer participation in meeting the cost of premiums. The most common percentage paid by the employer was 50 percent, but the mean payment was 67 percent. See U.S. Senate, Report of the Committee on Labour and Public Welfare, "Health Insurance Plans in the United States", (Washington: G.P.O. 1951) Part 2, p. 46.

(b) Claims Experience

All plans must of course set premium rates at levels expected to exceed the cost of their members' claims experience during the ensuing year, by an amount sufficient to cover the cost of administering the plan and accumulating an annual reserve as protection against unusually heavy claims in any year. As Table 11 indicates, the estimated average distribution of the premium dollar in 1952 was 87 cents for benefits, 9 cents for administration, and 4 cents for reserves.(1) In every plan the rates are related, either directly or indirectly, to the claims experience of the plan's membership, and consequently to the size of the reserves accumulated. Claims experience is measured in terms of the value of services rendered, and therefore reflects changes in the prices of individual services as well as changes in the per capita volume of services purchased.

The size of accumulated reserve funds depends on both the claims experience and the reserve policy of the plan. Some plans attempt to keep a certain fixed proportional relationship between claims and income; for example, claims might be expected to amount to 80 percent of income, with another 10 percent allocated to the reserve fund. Another

(1) In 1951, 75 Blue Shield Medical Care Plans (including 6 in Canada) reported an average ratio of 80:12:8 percent of total income for benefits, administration, and reserves. See Blue Shield Medical Care Plans, Financial Reports, 1951, (Chicago, 1952), p. 3.

approach is to maintain in reserve a fixed sum of money per participant.(1)

(i) Experience Rating. Only two of the plans deliberately vary their premium rates with their members' claims experience - a practice known as "experience rating". The British Columbia and Alberta plans maintain separate accounts for each of their employed groups and vary the premiums paid by the members of a group according to the group's claims experience, as indicated by the amount spent on claims by the group during a fixed period.(2) This practice is apparently based on the theory that each employed group is in a position to control the demand for services, and therefore the benefit expenditures on behalf of its members. In both plans, rates for a group are raised or lowered as the group's annual claims expenditure rises above or falls below 80 percent of premium receipts, i.e. the ratio required to accumulate a reserve fund equivalent in amount to six months' premiums, by paying a certain proportion of the group's monthly premiums into a stabilization account

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(1) For example, one plan aims to accumulate a reserve of $5 per participant, of which 65 percent is derived from the agreed sums withheld from the doctors' accounts, and the remainder is accumulated from members' annual premium payments.

(2) All groups with less than 125 lives at renewal date under the B.C. plan, or 350 lives under the Alberta plan, are treated as one unit. Experience-rating does not usually begin under the Alberta Plan until the second contract year.

over a five year period. At any annual renewal date, if the B.C. plan's reserve is equivalent to one year's premiums, 50 percent of it is refunded to the members; no refunds are permitted under the Alberta plan. When a reserve equal to six months' premium is achieved under either plan, the monthly rates for the next contract year are reduced to the amount required to provide for the costs of benefits and administration only. If, however, reserves are accumulating annually, but have not yet reached an amount equal to six months' premiums, the rates are reduced to the level which will achieve the desired reserve in five years. Where claims exceed the desired proportion of 80 percent of premiums, the rates are increased by an amount which may be expected to achieve a reserve equivalent to six months' premiums within five years.

In addition to these variations in the rates charged particular employed groups, the basic rates upon which this experience rating operates are also changed in line with the overall claims experience, which in turn is influenced by changes in both utilization of services and doctors' fees. For example, benefit expenditures for all members of the British Columbia plan in 1949 and 1951 amounted to 85 and 92 percent of income, as shown in Table 14 (see p.94.) and near the end of these two fiscal years the plan increased its basic premium rates. The Alberta plan also increased

its basic premium rates, and took other action to reduce its liabilities, following a deficit on operations in 1950 when its claims amounted to 98 percent of income.

(ii) Premium Adjustment for Female Membership. In addition to these changes in premiums in accordance with the claims experience of each group, the British Columbia plan further varies the contribution rates for each group according to the proportion of female employees it contains. As will be noted in the next section,(1) the claims experience of female members is considerably higher than that of males in the wage-earning years. In the British Columiba plan, if a group contained 11 percent or more female employees, the basic premium rate was loaded on a graduated scale for female enrollment in 1952, as follows:

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(1) See p.107.

Subscribers	MONTHLY PREMIUM RATES ACCORDING TO PERCENT OF FEMALE MEMBERSHIP									
	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
	$	$	$	$	$	$	$	$	$	$
Single persons	2.60	2.86	2.99	3.12	3.25	3.38	3.51	3.64	3.77	3.90
Families	7.80	8.06	8.19	8.32	8.45	8.58	8.71	8.84	8.97	9.10

As yet the practice of adjusting premium rates for female membership has not been used by any of the other plans in Canada.

(iii) Reserve Ratios. Other plans in Canada appear to vary their contribution rates with the claims experience of their total membership over a period of time. When claims account for too large a proportion of annual income, or when the fixed reserve fund is dangerously low, a plan may attempt to rectify this situation either by increasing contribution rates, which is the usual procedure, or by reducing the benefits provided without changing premiums. On the average, as shown in Table 14, the "service" plans have been paying claims amounting to about 85 percent of income, ranging between 72 percent in the Physicians' Services plan in 1949 and 98 percent in the Regina plan in 1952. In almost every case where a plan experienced claims of more than 80 percent of its income, its rates were subsequently increased to a level expected to achieve the desired ratio. For example, in 1950, three plans experienced claims of 83, 85 and 88 percent of income respectively, and each increased its rates in the fall of 1950 or early 1951. In 1951 PSI and MMC paid out 82 and 92 percent in claims; the former raised its premiums in August 1951, and the latter in February, 1952. The Regina plan, which as mentioned paid out over 98 percent of its 1952 income in benefits, increased its premiums in December 1952.

Table 14. PERCENTAGE DISTRIBUTION OF INCOME BETWEEN BENEFITS, ADMINISTRATION, AND OPERATING SURPLUS, EIGHT NON-PROFIT MEDICAL INSURANCE "SERVICE" PLANS, FISCAL YEARS 1949-1952

Plan	1949			1950			1951			1952		
	Benefits	Admin.	Operating Surplus	Benefits	Admin.	Operating Surplus	Benefits	Admin.	Operating Surplus	Benefits	Admin.	Operating Surplus
MSA - B.C.	85.2	6.3	8.5	81.4	6.5	12.1	92.0	6.7	1.3	92.2	5.8	2.0
MSI - Alberta	88.5	14.3	-2.8	94.7	12.9	-10.6	81.3	14.2	4.5	79.7	16.2	4.1
MSSI - Sask.	75.4	15.7	8.9	83.0	13.4	3.6	82.2	13.4	4.4	84.0	10.3	5.7
GMS - Sask.	-	-	-	85.2	9.3	5.5	89.3	7.5	3.2	98.4	9.0	-7.4
MMS - Manitoba	87.9	10.3	1.8	88.3	11.5	0.2	83.1	10.0	6.9	87.8	9.1	3.1
PSI - Ontario	72.1	14.0	13.9	78.7	11.5	12.8	82.2	9.2	8.6	83.3	9.0	7.7
WMS - Ontario	87.0	7.3	5.7	82.3	7.3	10.4	85.8	7.1	7.1	91.1	7.6	1.3
MMC - N.S.	Not available			93.8	11.9(a)	-5.7(a)	92.2	10.8	-3.0	84.8	9.8	5.4
Eight "Service" Plans	84.4	8.6	7.0	88.0	9.0	3.2	86.2	8.8	5.0	87.6	8.4	4.0

(a) Estimated.

Note: The proportion of income allotted to benefits represents the amount actually paid to physicians, and does not represent the full amount of allowed claims based on fee schedules for services provided, which in some cases would amount to more than 100% over the income dollar, e.g., see Table 22 for actual medical claims received and pro-rated payments. The operating surpluses are made possible by pro-rating payments to the physicians.

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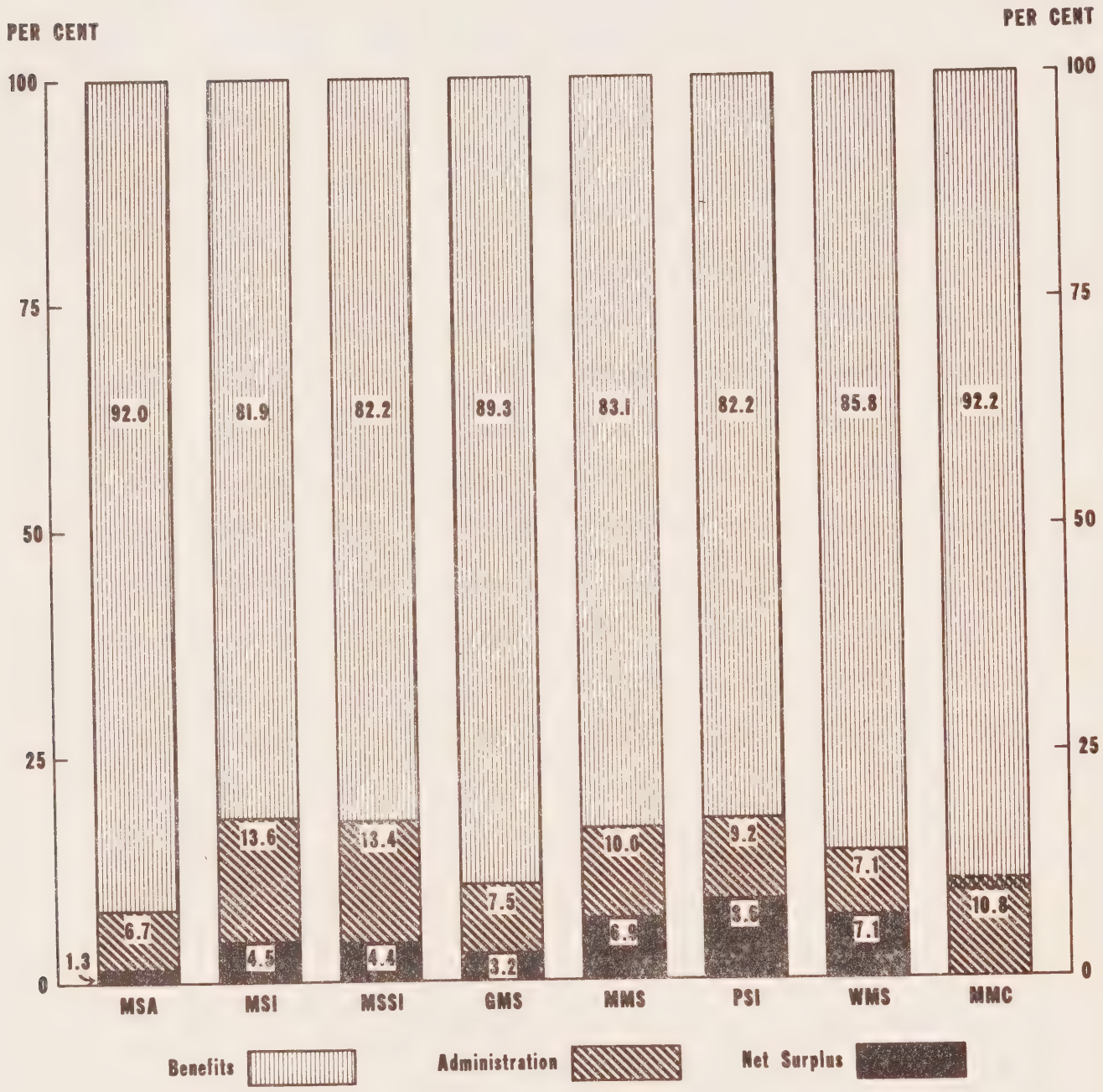
EXPENDITURES

Expenditures by the non-profit medical insurance plans amounted to $17.4 million in 1951 and $23.0 million in 1952, as shown in Table 11. Of these amounts, $15.6 million and $20.7 million were spent on medical care benefits in these two years, and the remaining $1.8 million and $2.2 million went to cover the costs of administering the plans. Reserves were augumented by $767,000 in 1951, and by $928,000 in 1952.

When the 1952 premium dollar was allocated to these various categories of expenditure, it was found (Table 11) that 87 cents was spent on benefits, 9 cents on administration, and 4 cents was added to reserves. It should be noted, however, that these figures include estimates of the proportions of administrative costs and of reserves which are applicable to the medical insurance operations of six plans which offer both medical and hospital benefits. Table 14 shows the income allocation for benefits, administration and reserves, of the eight plans which provide medical benefits only, between 1949 and 1952. For these eight plans, the income dollar in 1952 was divided into 88 cents for benefits, 8 cents for administration, and 4 cents for reserves. Benefit expenditures ranged between 80 and 98 cents on the income dollar for individual plans. Chart 4 illustrates the distribution of the 1951 premium dollar of these eight plans.

CHART 4

PERCENTAGE DISTRIBUTION OF INCOME, EIGHT NON-PROFIT MEDICAL INSURANCE SERVICE PLANS, 1951



SOURCE: Table 14

BENEFITS

Although it has been possible to indicate the overall financial experience of the non-profit plans in 1952, together with estimates of their 1953 experience, detailed statistics on the plans' financial operations were not collected beyond the year 1951. The data which follow, therefore, relate largely to that year.

The non-profit medical insurance plans spent 86 percent of their income, or $15.6 million, on medical care benefits in 1951 for their 1.6 million members. This is equivalent to an expenditure of $11 for each participant.(1)

However, this $11 figure is based on the total of all plans, without distinction between enrollees under the comprehensive and the limited contracts offered by many of the plans. A more accurate assessment of the per capita expenditures on benefits provided by these plans would be obtained by segregating the expenditures under these two types of contract.

The per capita expenditures of 13 plans under the various comprehensive and limited contracts which were available in 1949, 1950 and 1951 are shown in Table 15. Expenditures under eight of the plans offering a fairly complete range of benefits in 1951 ranged from $11.52 per capita under the Saskatoon "A" group contract to $19.36 under the B.C. contract, with an average of $16.15 for the twelve contracts.

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(1) Estimates for 1953 would reach about $28 million or $13 per capita.

Table 15. PER CAPITA EXPENDITURES ON MEDICAL CARE BENEFITS AVAILABLE UNDER "COMPREHENSIVE" AND "LIMITED" CONTRACTS, THIRTEEN NON-PROFIT PLANS, 1949, 1950, 1951, AND PERCENTAGE INCREASE BETWEEN 1949 AND 1951

Plan	Contract	Per Capita Expenditures[a]			Percentage Increase Over 1949
		1949	1950	1951	
		$	$	$	%
Comprehensive Contracts					
M.S.A. - B.C.		16.76	16.95	19.36	15.5
M.S.I. - Alta.		10.74	15.25	13.56	26.3
M.S.S.I. - Sask.	Individual	11.54	12.60	13.68	18.5
	A		13.32	11.52	
	B	-	12.84	15.00	16.8[b]
	Community	-	10.20	12.12	18.8[b]
G.M.S. - Sask.		11.64[c]	12.00	13.80	18.6
M.M.S. - Man.	B	11.48	14.01	15.49	34.9
	Extended	-	13.14[e]	17.23	31.1[b]
P.S.I. - Ont.	Blue	11.34	12.31	14.69	29.5
W.M.S.I. - Ont.	MS & O	15.85	15.04	16.37	3.3
A.M.S. - Ont.	800	15.12	-	-	-
M.M.C. - N.S.	M.S. & O.	(f)	14.30	14.68	(f)
All plans[d]		14.57	14.87	16.15	10.8
Limited Contracts					
M.M.S. - Man.	A	2.94	3.37	3.82	29.9
	Limited	-	2.14[e]	2.99	39.7[b]
P.S.I. - Ont.	Green	5.29	4.75	5.29	0
	Brown	-	-	5.08	-
W.M.S.I. - Ont.	S & O.	7.20	6.88	6.52	-9.4
C.M.S.F. - Ont.	S & O.	4.91	7.75	6.75	37.5
A.M.S. - Ont.	"1600"	6.48	6.72	6.94	7.1
	"900"	-	3.96	5.82	47.0[b]
	Group M.S.	4.56	5.52	5.77	26.5
S.S.Q. - Que.	A	2.63	4.05	5.11	94.3
	B	5.07	5.60	5.36	5.7
Q.H.S.A. - Que.	Medical Surgical[d]	6.51	6.04	6.26	-3.8
M.H.S.A. - Maritimes	Medical Surgical	6.54	7.75	8.52	30.3
M.M.C. - N.S.	S. & O.	(f)	(f)	(f)	(f)
All Plans[d]		6.22	6.14	6.42	3.2

(a) The amounts spent by any two plans cannot be compared, since the benefits offered, the fee schedules used, and the demand for benefits vary widely between plans.
(b) Increase over 1950.
(c) For the year 1948 (Group Health Assoc.)
(d) Estimated.
(e) Based on five months experience only.
(f) Not available.

Note: The per capita expenditures in this table are based on the actual payments to doctors, and do not represent the full amount of allowed claims for services.

In 1950, the average expenditure was under $15.00. On the other hand, the cost of benefits extended through limited contracts in 1951 varied from $2.99 per capita under Manitoba's Limited Medical (non-group) contract to $8.52 under the Maritime Hospital plan, with an average of $6.42 for the fifteen limited contracts.

It should be noted that the four largest service plans - Physicians' Services, the British Columbia plan, the Manitoba plan, and the Windsor plan - each spent between $14.50 and $19.50 per capita on their comprehensive contracts in 1951. A figure of about $16.00 then, represented the average per capita cost of providing the wage-earner and his dependents with a fairly complete range of medical care benefits under the non-profit medical insurance plans in 1951.

(1) Trends in Benefit Expenditure Per Capita

Over the period 1949 to 1951, per capita benefit claims met by the plans rose by 6.4 percent from an average of $10.34 to $11.00 per member. Expenditures per member under comprehensive insurance increased by almost 11 percent over 1949, varying from a low of 3 percent under the Windsor plan to a high of 35 percent under Manitoba's "B" (comprehensive) contract.

Under those plans offering "limited" contracts, the two greatest increases in 1951 expenditures over 1949 occurred under the S.S.Q. "A" contract - a 94 percent

expansion - and under A.M.S. "900" contract - one of 47 percent; no increase at all was experienced under P.S.I.'s "green" contract, while the Windsor and Quebec Blue Cross plans actually reduced their per capita expenditures during this period.

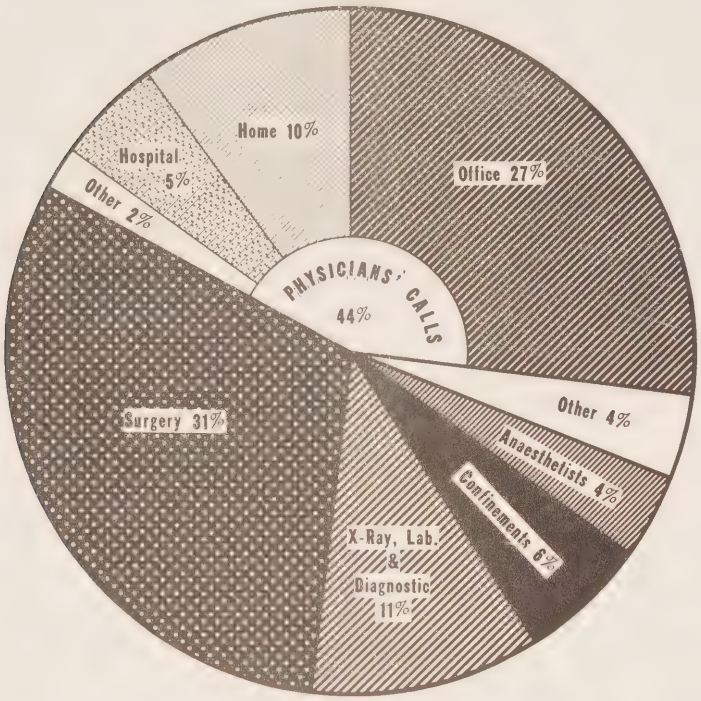
A more detailed picture of the composition of the medical care expenditures made by the comprehensive plans is given below.

(2) Costs of Various Services

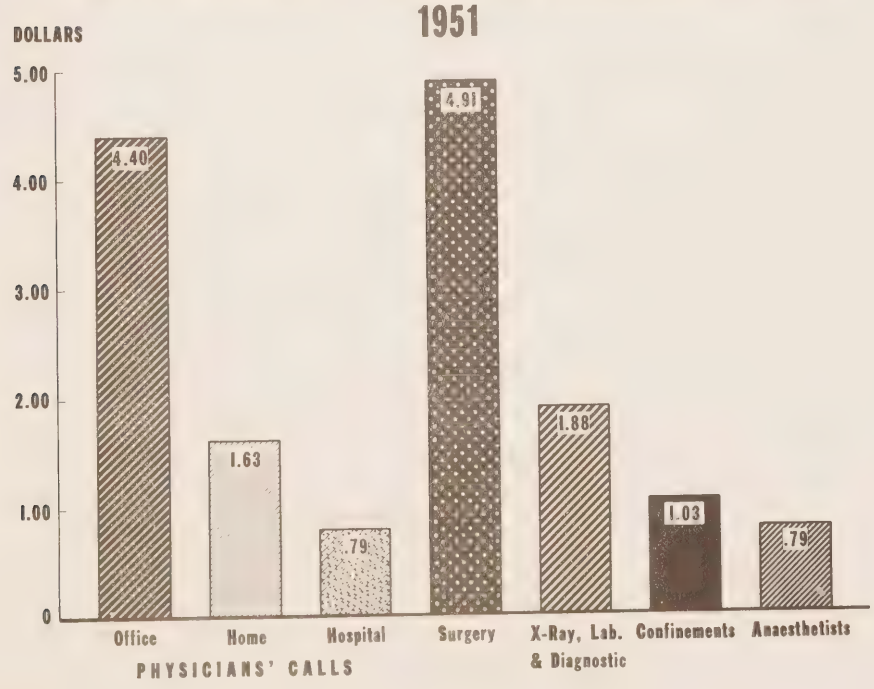
The comprehensive medical insurance plans spent about $10½ million on medical benefits in 1951, or, as noted previously, $16 per member per year or $1.34 per month. When this amount is allocated among the various services provided to members, it is found that a monthly average of about 59 cents per member was spent on physicians' calls in 1951, 41 cents on surgery, 11 cents on X-rays, and 9 cents on confinements, the four major expenditure items. A breakdown of the 1951 expenditures on benefits among the major items of medical care was provided for this study by the eight comprehensive service plans operating in Canada in that year. This breakdown is shown in detail in Appendix VI, and is summarized in Table 16 which indicates the average annual expenditures of the eight plans. Average annual expenditures per capita, and the percentage distribution of the benefit dollar on each item of service in 1951 are also illustrated in Chart 5.

CHART 5

PERCENTAGE DISTRIBUTION OF BENEFIT EXPENDITURES, BY ITEM OF SERVICE, EIGHT COMPREHENSIVE PLANS, 1951



AVERAGE EXPENDITURE PER CAPITA ON BENEFITS, BY ITEM OF SERVICE, EIGHT COMPREHENSIVE PLANS, 1951



Source: Table 16

Table 16. PERCENTAGE DISTRIBUTION OF EXPENDITURES, AND AVERAGE, LOW, AND HIGH ANNUAL EXPENDITURES PER CAPITA ON THE MAJOR ITEMS OF MEDICAL CARE BENEFITS UNDER EIGHT NON-PROFIT COMPREHENSIVE MEDICAL INSURANCE PLANS, BY ITEM OF SERVICE, 1951

Item of Service	Expenditures			
	Percentage Distribution	Annual Per Capita		
		Average	Low	High
		$	$	$
Physicians' Calls	44.3	7.11	5.56	7.86
Office	27.5	4.40	3.00	5.56
Home	10.2	1.63	.82	2.88
Hospital[a]	4.9	.79	.55	1.40
Other calls	1.7	-	-	-
Surgery	30.4	4.91	3.11	6.32
Confinements	6.4	1.03	.55	1.58
Anaesthetists	4.2	.79	.48	.96
X-ray Services	8.0	1.28	.76	1.73
Laboratory and Diagnostic	2.9	.60	.17	.96
Other[b]	3.8	-	-	-
TOTAL	100.0	16.02	13.32[c]	19.36[c]

Source: Based on Appendix VI.

(a) For non-operative cases only.

(b) All other residual items.

(c) These are not totals of the lowest and highest expenditures on particular items, but are the lowest and highest expenditures on all services.

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Although the plans shown in Appendix VI are all comprehensive plans, it must not be inferred that it is valid to draw comparisons between the average expenditure of any two plans on a particular item of service. As previously mentioned, the benefits offered by different plans vary considerably, in terms of waiting-periods, dollar limitations, extra-billing by specialists, and so on. Furthermore, the environment in which each plan operates will influence its costs. Community health facilities and personnel are of course important determinants of the use of medical services; for example, in areas where hospital insurance plans or certain public health programs are available, it is probable that there will be a different pattern of demand for medical services. Moreover, the age-sex and income pattern of a plan's membership will affect the demand for the benefits available, and therefore the costs of providing them. In addition, the unit cost of an item of service may vary as the provincial fee schedules vary. If a plan discounts or "prorates" the accounts submitted by participating doctors, the amounts paid for services will of course be lower than if it pays 100 percent of the fee schedule rates. Some plans pay all-inclusive rates for surgical and obstetrical cases, including the fee for the operation, certain diagnostic and laboratory services, and physicians' calls in hospital. And finally each plan may follow a different procedure in reporting its expenditures, some listing in detail the expenditure on each item, and others lumping the costs of various

services together. For all these reasons, it is obvious that the national averages shown in Table 16 are only approximations to the actual expenditures on the various items of service listed. To illustrate the influence of these differences between plans on the costs of benefits provided, Table 16 also shows the range between the lowest and highest annual expenditures per participant on each item of service.

(a) Physicians' Calls

Physicians' calls were the most costly item of service in 1951, amounting to $7.11 per member and ranging from a low of $5.56 to a high of $7.86. Included in this average was an expenditure of $4.40 for office calls, $1.63 for home calls and 79 cents for hospital calls. The remainder consisted of night and holiday calls, and consultations. In individual cases, it may be noted from Appendix VI that some plans spent more on home calls than on hospital attendances, and others spent less. This variation is due partially to different methods of paying for hospital calls in surgical cases, and partially to the influence of hospital insurance on medical care, and other factors. Payments for home calls in 1951 varied from 82 cents to $2.88 per participant and for hospital calls from 55 cents to $1.40.

(b) Surgery, Confinements, and Other Services

The second largest item of expenditure was surgery, costing the plans an annual average of $4.91 per

member in 1951. The lowest per capita expenditure on this item was $3.11 and the highest was $6.32. Next in order of size was expenditure on x-ray services, amounting to an average of $1.28 per person annually for the eight plans, and ranging from a low of 76 cents to a high of $1.73. Confinements accounted for an annual average of $1.03 per participant, varying from 55 cents to $1.58. An average of 79 cents was paid to anaesthetists, and 60 cents was spent for laboratory and other diagnostic services.

The per capita expenditures of the reporting plans on each of these items of service, in selected years, are shown in greater detail in Appendix VI.

(c) Breakdown of Surgical Costs

It is of interest to examine the costs of surgery a little more closely. Three of the comprehensive plans have provided more detailed information about their 1951 surgical expenditures, as shown in Table 17. It should be mentioned that these three plans may have different interpretations of "major" and "minor" surgery.

Having in mind the non-comparability of expenditures between plans as noted above, it is striking that, in each case, the proportions spent on surgical services are about the same.

Table 17. EXPENDITURES PER PARTICIPANT MONTH AND PERCENTAGE DISTRIBUTION OF EXPENDITURES ON SELECTED ITEMS OF SURGICAL BENEFITS, THREE NON-PROFIT MEDICAL INSURANCE PLANS, 1951

Item of Surgery	Plan 1		Plan 2		Plan 3	
	Expenditure		Expenditure		Expenditure	
	Per Participant Month	Per Cent of Total	Per Participant Month	Per Cent of Total	Per Participant Month	Per Cent of Total
	Cents		Cents		Cents	
General Major Surgery	18.2	14.9	19.4	14.2	16.8	14.8
Appendectomies	4.7	3.8	5.5	4.0	6.8	6.0
Herniotomies	2.2	1.8	-	-	1.9	1.7
Cholecystectomies	1.5	1.3	-	-	2.0	1.7
Other[a]	9.8	8.0	13.9	10.2	6.1	5.4
Gynaecology	7.0	5.8	5.5	4.1	5.5	4.9
D. and C.'s	-	-	1.2	0.9	1.4	1.3
Hysterectomies	-	-	-	-	1.1	1.0
Other[a]	7.0	5.8	4.3	3.2	3.0	2.6
Minor Surgery	9.1	7.4	10.3	7.6	9.9	8.7
Tonsils & Adenoids	4.3	3.5	4.8	3.5	4.7	4.1
Circumcisions	-	-	0.9	0.7	-	-
Hemorrhoidectomies	-	-	-	-	0.6	0.5
Other[a]	4.8	3.9	4.6	3.4	4.6	4.1
Surgical Assistants	-	-	0.1	0.1	1.5	1.3
Fractures	2.9	2.4	3.5	2.5	2.4	2.2
Total Surgery	37.2	30.5	38.8	28.5	36.2	31.9

Source: Data submitted by individual plans. See also Tables 24 and 27.

(a) Items of surgery for which no separate figure is shown are included in "Other".

Each of these three plans spent about half of their total surgical expenditures on major surgery, excluding gynaecological operations. Each paid between 36 and 39 cents per member per month for all surgical benefits, or between 29 and 32 cents of their benefit expenditure dollar; between 14 and 15 cents of the dollar was committed to general major surgery.

If the residual items are excluded, it will be noted in Table 17, that in each of these plans, appendectomies, tonsillectomies and fractures were the first, second, and third largest single items of expenditure. Appendectomies accounted for 4 to 6 percent of total expenditures, tonsillectomies for 3.5 to 4 percent, and fractures for 2 to 2.5 percent. In two of the plans, fourth and fifth place in order of size went to herniotomies and cholecystectomies. In the next chapter there is a further discussion of these items in terms of the volume of each type of service provided to the members of these three plans.

(3) Benefit Costs by Age and Sex

In the previous section, reference was made to the effect of age-sex differences in the membership of the various plans on the comparability of their cost data. Two plans have provided statistics showing their claims experience by age and sex; these data indicate the very important influence of the age and sex of members on the cost

of the services they receive. The experiences of these two plans show that females in the age groups 21 to 40 years and 41 to 60 years, particularly the former, require more than a proportional share (in relation to their numbers) of the total expenditures on benefits for all females, or for all persons, male and female, in each of these age groups. Consequently girls under 21 years of age require less than a proportional share of the expenditures for all females; however, they require a share of benefits roughly proportional to the percentage they represent of all persons in their age group.

Unlike the female members, males aged 21 to 40 years require less than a proportional share of total expenditure on benefits for all males, or for all persons in these age groups, while males of 41 to 60 years require a share of benefit payments which is more than proportional for all males but less than proportional for all persons of these ages. The expenditure on behalf of boys under 21 years is approximately proportional to the percentage they represent of total male enrollment, or of all persons under 21 years.

It must be recognized that there is a wide variation in the demand for medical services between different age groups in each sex. Both the volume of services required and the prices of the various services which are peculiar to certain age-sex groups have considerable influence on the benefit expenditures made on behalf of any one age-sex group.

For example, the cost of and frequency of demand for obstetrical services will obviously increase the expenditure required by women in the child-bearing age groups. Such factors must be kept in mind in the discussion which follows concerning the percentage distribution of benefit expenditures by age group and by sex.

(a) Proportional Distribution of Expenditures

(i) By Age Group. In Plans A and B respectively, 40 and 35 percent of the members were under 21 years of age. But these members accounted for only 32 and 28 percent of total expenditures on benefits, as shown in Table 18. The situation is reversed for adults in the age groups 21 to 40 years. These groups represented 40 percent of A's membership in 1950, and required 45 percent of the benefit expenditures; 37 percent of B's members were between these ages in 1951, and 39 percent of B's total expenditures were made on their behalf.

Older members, generally, require slightly more than a proportional share of a plan's benefit expenditures. Ten percent of Plan A's membership were over 50 years of age and received 12 percent of the expenditure on benefits by that plan, while 15 percent of Plan B's members were over 50 years and obtained 19 percent of B's benefit expenditures. Although the expenditures on older members do not constitute a serious problem for these plans at the present time, it cannot be concluded from this information that these cost

Table 18. PERCENTAGE DISTRIBUTION OF ENROLLMENT AND EXPENDITURES ON MEDICAL CARE BENEFITS, BY AGE AND SEX, TWO NON-PROFIT COMPREHENSIVE MEDICAL INSURANCE PLANS, 1950 AND 1951

Age	Plan A (1950)						Plan B (1951)					
	Males		Females		All Members		Males		Females		All Members	
	Per Cent of		Per Cent of		Per Cent of Total		Per Cent of		Per Cent of		Per Cent of Total	
	Members	Expenditure	Members	Expenditure	Members	Expenditure	Members	Expenditure	Members	Expenditure	Members	Expenditure
Under 2 years[a]	4.2	3.8	4.3	3.0	4.3	3.3	4.1	8.5	4.2	4.6	4.2	6.3
2 - 4 yrs.	12.3	11.2	11.2	5.9	11.7	8.1	5.5	5.7	5.5	3.5	5.5	4.4
5 - 10 yrs.	9.7	10.9	9.3	6.6	9.5	8.3	10.7	10.7	10.8	6.6	10.8	8.4
11 - 15 yrs.	13.7	13.0	15.4	12.3	14.6	12.6	8.2	6.4	8.2	4.2	8.2	5.1
11 - 20 yrs.												
16 - 20 yrs.							6.1	4.2	6.7	3.9	6.4	4.0
Total 0-20 yrs.	39.9	38.9	40.2	27.8	40.1	32.3	34.6	35.5	35.4	22.8	35.1	28.2
21 - 30 yrs.	18.7	16.3	23.2	32.0	20.9	25.5	18.0	13.9	20.8	25.4	19.4	20.5
31 - 40 yrs.	18.7	16.3	18.5	21.5	18.6	19.3	17.1	13.7	18.1	21.9	17.6	18.4
Total 21-40 yrs.	37.4	32.6	41.7	53.5	39.5	44.8	35.1	27.6	38.9	47.3	37.0	38.9
41 - 50 yrs.	11.4	11.5	9.3	9.7	10.3	10.4	13.4	13.6	12.4	14.2	12.9	14.0
51 - 60 yrs.	7.9	11.0	6.5	6.7	7.2	8.5	10.7	13.3	9.0	10.4	9.8	11.6
61 - 70 yrs.[b]	3.1	5.6	1.7	2.1	2.4	3.5	5.2	8.2	3.7	4.3	4.5	6.0
Over 70 yrs.[b]	0.4	0.4	0.5	0.2	0.4	0.3	1.1	1.8	0.6	0.9	0.8	1.3
Total over 50 yrs.	11.4	17.0	8.7	9.0	10.0	12.3	17.0	23.3	13.3	15.6	15.1	18.9
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Data provided by individual plans.

(a) Restricted eligibility for children under 6 months under Plan A.
(b) Restricted eligibility for adults over 65 years under Plan A.

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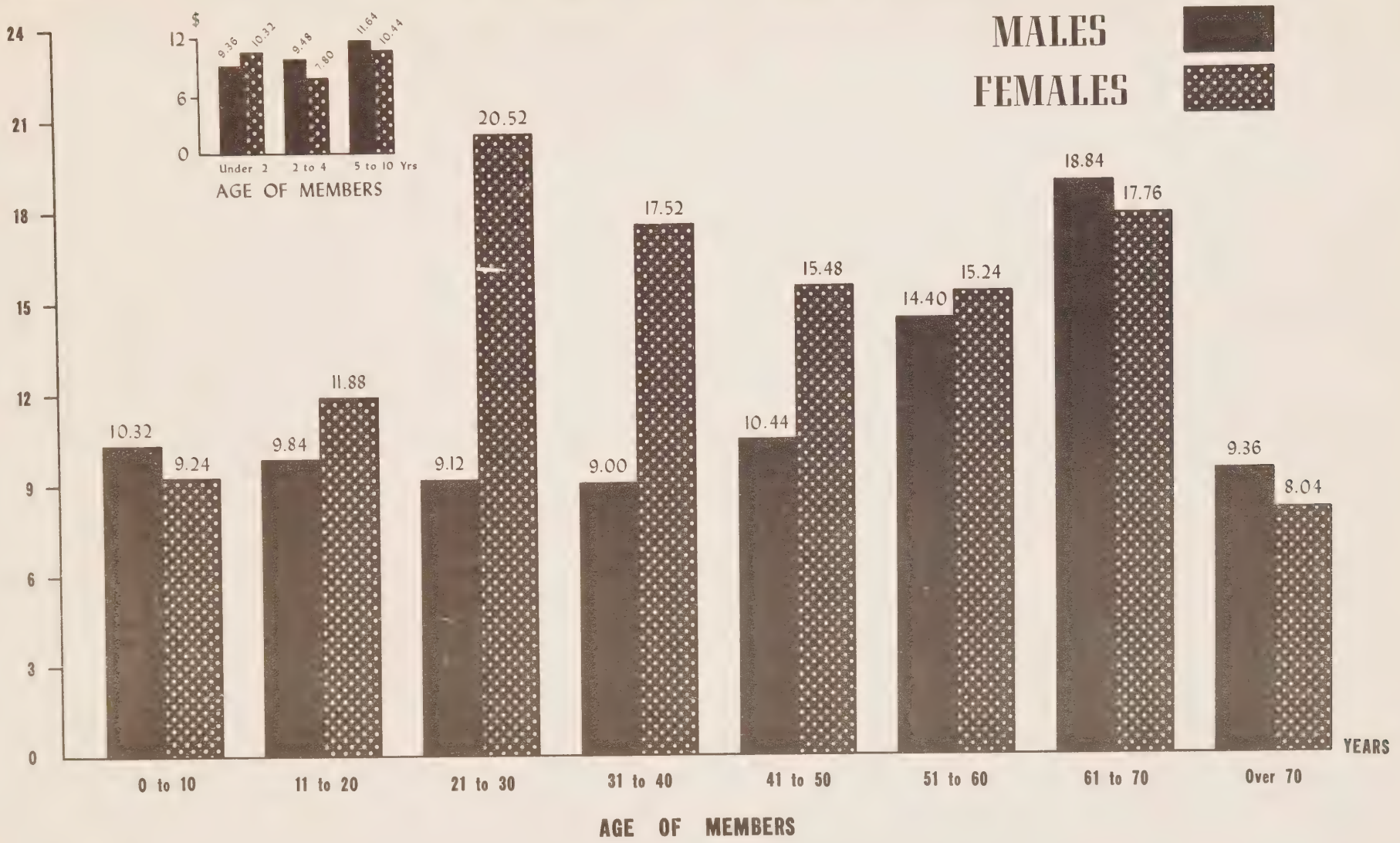
relationships would continue to hold if the plans were to extend their coverage to a greater proportion of elderly people, since the older age groups now covered represent a selected group of individuals, for the most part either actively employed or recently retired.

It should be observed that when there is heavy expenditure on behalf of one or two age groups, as in the case of child-bearing females, the proportion of total expenditures for that sex received by any other age group will be correspondingly small. When expenditures on females' benefits are examined in relation to female membership, it can be seen from Charts 6 and 8 that females under 21 years of age accounted for 40 percent of female membership, but only 28 percent of female expenditures in Plan A, and for 35 and 23 percent respectively in Plan B, or much less than a proportional share of each plan's expenditures for females. Girls between 2 and 4 years in Plan A and between 5 and 15 years in Plan B required the smallest proportional share of the plans' expenditures on females.

As would be expected, the opposite situation prevails among female members in the child-bearing age groups. As shown in Chart 6, 54 percent of Plan A's expenditures on females were made on behalf of the 42 percent of female members in the age groups 21 to 40 years; similarly, Chart 8 indicates that while 47 percent of Plan B's female expenditures were required on behalf of women in these age groups,

CHART 6 - PERCENTAGE DISTRIBUTION OF ENROLLMENT AND EXPENDITURE ON MEDICAL CARE BENEFITS, BY AGE AND SEX, PLAN A, 1950

CHART 7 - ANNUAL EXPENDITURE PER CAPITA ON MEDICAL CARE BENEFITS, BY AGE AND SEX, PLAN A, 1950



Source: Table 20

they represented only 39 percent of all female members. Older females require only slightly more than a proportional share of all female benefit expenditures. Women over 50 years of age accounted for 9 percent of female enrollment and expenditure in Plan A, and for 13 and 15 percent respectively in Plan B.

Among the male members of these two plans, the expenditures are distributed much more evenly. Forty percent of A's males were under 21 years of age, and required 39 percent of all male expenditures; 35 percent of B's males were under 21 years, and they required 36 percent of Plan B's expenditures on male benefits. A smaller share of benefit expenditures was required by men in both plans who were between 21 and 40 years of age. In Plan A, 37 percent of these male members accounted for only 33 percent of all male expenditures, while 35 percent of Plan B males of these years required only 28 percent of male expenditures. Older males make heavier demands on benefits expenditures, due probably to increases in both the volume of services required[1] and the prices of these particular services. Plan A males over 50 years of age represented 11 percent of all males in 1950, and required 17 percent of all expenditures on male benefits. Plan B males over 50 years accounted for 17 percent of all males and 23 percent of all male expenditures in 1951.

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(1) Unfortunately information concerning the volume of services received by age and sex is not available.

(ii) By Sex. Because of the previously noted distortion in the proportion of expenditures received by any one age group as a result of the heavy requirements of other age groups, it is advisable to examine also the proportional distribution of expenditures in each age group, as in Table 19, to determine whether a particular sex group has received a disproportionate share of the benefit expenditures for that age. It is to be expected that males and females in any one age group may receive quite different proportions of expenditure, since varying illness experiences require services which differ in volume and prices.

One of the most striking facts to be noted from Table 19 is that in Plan B boys under 16 years consistently received a larger share of the benefit expenditures than girls of the same age groups. This fact can be explained in terms of the slightly higher proportion of boys to girls but, more important, the greater per capita expenditures on their behalf. A similar pattern was found in Plan A in 1950, with the exception of the age group from birth to 2 years.

In the older age groups the reverse is true. In both Plans A and B it appears that males aged 16 years and over consistently required a smaller share of the expenditures on behalf of each age group, while females in these age groups required a larger share. The greatest difference between males and females in both Plans A and B occurred in the age groups 21 to 40 years.

Table 19. PERCENTAGE DISTRIBUTION OF ENROLLMENT AND EXPENDITURES ON MEDICAL CARE BENEFITS IN EACH AGE GROUP, BY SEX, TWO NON-PROFIT COMPREHENSIVE MEDICAL INSURANCE PLANS, 1950 AND 1951

Age	Plan A (1950)						Plan B (1951)					
	Males		Females		All Members		Males		Females		All Members	
	Per Cent of Members	Per Cent of Expend.	Per Cent of Members	Per Cent of Expend.	Per Cent of Members	Per Cent of Expend.	Per Cent of Members	Per Cent of Expend.	Per Cent of Members	Per Cent of Expend.	Per Cent of Members	Per Cent of Expend.
Under 2 years[a]	49.3	46.5	50.7	53.5	100.0	100.0	50.4	57.4	49.6	42.6	100.0	100.0
2 - 4 yrs.	52.5	57.3	47.5	42.7	100.0	100.0	51.0	54.2	49.0	45.8	100.0	100.0
5 - 10 yrs.	51.2	53.8	48.8	46.2	100.0	100.0	50.8	54.3	49.2	45.7	100.0	100.0
11 - 15 yrs.	47.3	42.7	52.7	57.3	100.0	100.0	51.2	52.9	48.8	47.1	100.0	100.0
11 - 20 yrs.												
16 - 20 yrs.							48.9	44.2	51.1	55.8	100.0	100.0
Total 0 to 20 yrs.	50.0	49.6	50.0	50.4	100.0	100.0	50.5	53.3	49.5	46.7	100.0	100.0
21 - 30 yrs.	44.8	26.4	55.2	73.6	100.0	100.0	47.4	28.5	52.6	71.5	100.0	100.0
31 - 40 yrs.	50.5	34.8	49.5	65.2	100.0	100.0	49.7	31.4	50.3	68.6	100.0	100.0
Total 21 to 40 yrs.	42.7	30.0	57.3	70.0	100.0	100.0	48.5	29.9	51.5	70.1	100.0	100.0
41 - 50 yrs.	55.3	45.6	44.7	54.4	100.0	100.0	53.1	41.2	46.9	58.8	100.0	100.0
51 - 60 yrs.[b]	55.2	53.7	44.8	46.3	100.0	100.0	55.3	48.2	44.7	51.8	100.0	100.0
61 - 70 yrs.[b]	64.2	65.6	35.8	34.4	100.0	100.0	59.3	58.2	40.7	41.8	100.0	100.0
Over 70 yrs.[b]	48.1	51.8	51.9	48.2	100.0	100.0	65.1	59.5	34.9	40.5	100.0	100.0
Total over 50 yrs.	57.0	57.0	43.0	43.0	100.0	100.0	57.0	52.1	43.0	47.9	100.0	100.0
ALL AGES	50.2	41.3	49.8	58.7	100.0	100.0	51.1	42.3	48.9	57.7	100.0	100.0

Source: Data provided by individual plans.

(a) Restricted eligibility for children under 6 months under Plan A.
(b) Restricted eligibility for adults over 65 years under Plan A.

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(iii) Age and Sex. In order to analyze the expenditure pattern for any specific age-sex group, four different relationships should be considered:

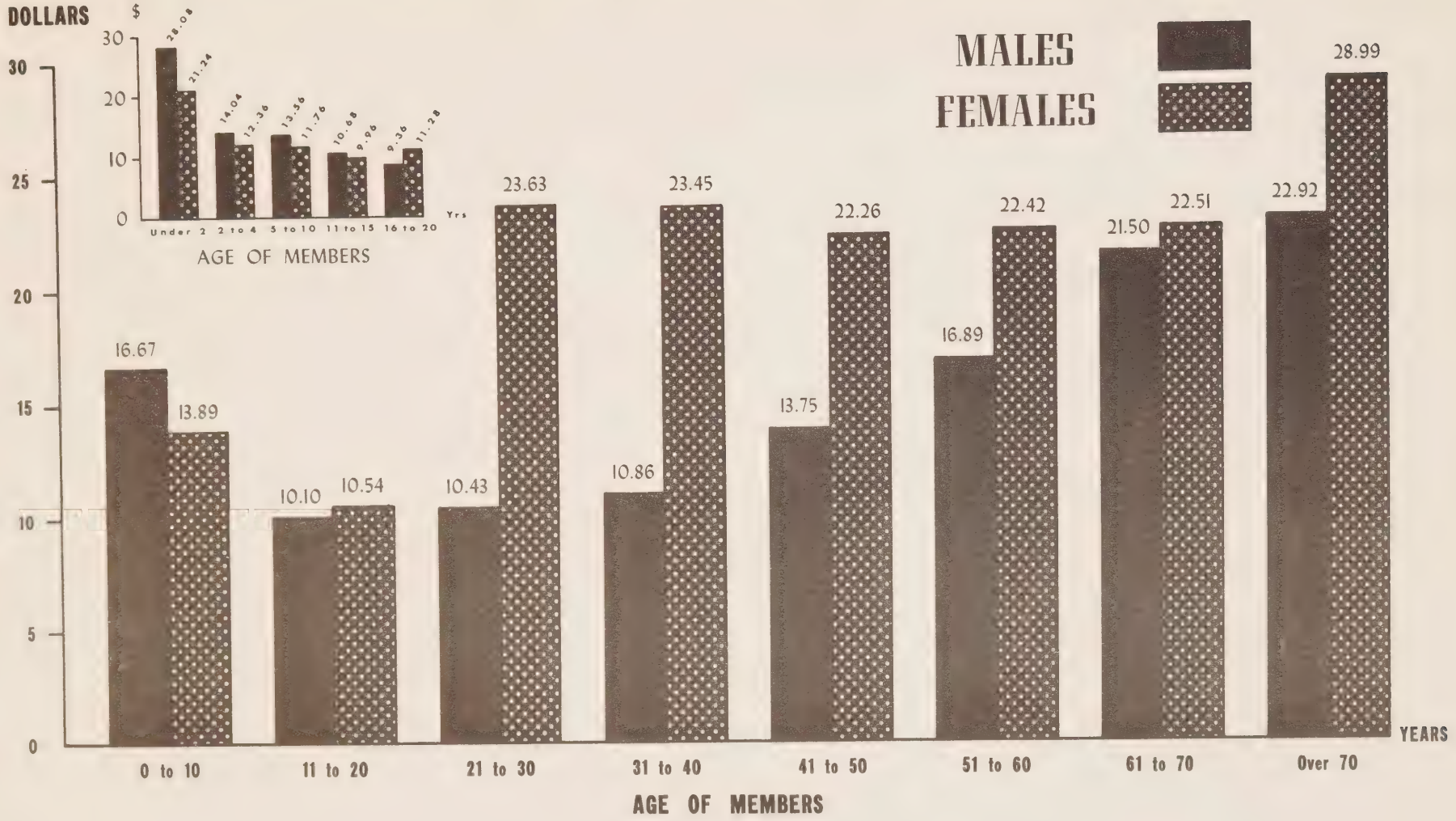
1. The proportion such a group bears to all other groups of (a) the same sex, as in Table 18, and (b) the same ages, as in Table 19.
2. The relationship of the average per capita expenditure on benefits on behalf of such a group to the average per capita expenditure for (a) that sex, and (b) that age group, as in Table 20.

For example, females in the age group 21 to 30 years accounted for one-third of all female expenditure, and three-quarters of total expenditures for both sexes of that age group in Plan A in 1950. Yet they represented less than one-quarter of all females, and slightly more than half of all members of that age. Thus it may be said that they required a larger share of the expenditures on behalf of both their sex and their age group. This point is borne out by reference to Table 20, which shows that the per capita expenditure for this group was $20.52, much higher than the averages of $14.88 for all females, or $15.36 for all persons aged 21 to 30 years.

The same pattern is revealed for Plan B in 1951, where women of 21 to 30 years of age accounted for one-quarter of all female expenditure and three-quarters of all

CHART 8 - PERCENTAGE DISTRIBUTION OF ENROLLMENT AND EXPENDITURE ON MEDICAL CARE BENEFITS, BY AGE AND SEX, PLAN B, 1951

CHART 9 - ANNUAL EXPENDITURE PER CAPITA ON MEDICAL CARE BENEFITS, BY AGE AND SEX, PLAN B, 1951



Source: Table 20

expenditures for persons of both sexes aged 21 to 30 years, although they amounted to only one-fifth of female enrollment and one-half of all members that age. Annual per capita expenditures of $23.63 were considerably greater than the averages of $19.32 for all females or $17.40 for all persons 21 to 30 years of age. In both plans, however, males in this age group received less than a proportionate share of the expenditures for their age and for their sex.

(b) Per Capita Expenditures

Although the distribution of membership by age and sex is fairly comparable between Plans A and B, as indicated in Table 18 and Charts 6 and 8, (with the exception of the age group 2 to 4 years, and females in the group 41 to 50 years), it is of doubtful validity to compare the cost experience of the two plans on a per capita basis. In addition to Plan B having 8 percent more members in the age groups over 40 years, it serves an area that is largely industrial, and operates under a higher fee schedule. Plan A has a younger membership, enrolls rural and individual members, and operates under a lower fee schedule. Furthermore, the plans have different waiting-periods and other limitations on benefits or enrollment. Yet certain experiences are common to each plan.

Medical care for females is considerably more costly on a per capita basis that for males, particularly in the middle age groups, Table 20 and Charts 7 and 9 indicate.

Table 20. AVERAGE ANNUAL EXPENDITURE PER MEMBER ON MEDICAL BENEFITS, BY AGE AND SEX, TWO NON-PROFIT MEDICAL INSURANCE PLANS, 1950 AND 1951

Age	Plan A			Plan B				
	Average Cost Per Member			Average Cost Per Member				
	1950			1950		1951		
	Male	Female	All Members	Male	Female	Male	Female	All Members
	$	$	$	$	$	$	$	$
Under 2 years	9.36(a)	10.32(a)	9.84(a)	24.12	17.76	28.08	21.24	24.72
2 - 4 years	9.48	7.80	8.64	13.68	12.00	14.04	12.36	13.20
5 - 10 yrs.	11.64	10.44	11.04	11.76	11.52	13.56	11.76	12.72
11 - 15 yrs.	9.84	11.88	10.92	8.88	9.00	10.68	9.96	10.32
11 - 20 yrs.								
16 - 20 yrs.				9.24	12.48	9.36	11.28	10.32
21 - 30 yrs.	9.12	20.52	15.36	9.48	22.80	10.43	23.63	17.40
31 - 40 yrs.	9.00	17.52	13.08	9.96	21.96	10.86	23.45	17.16
41 - 50 yrs.	10.44	15.48	12.72	12.24	20.40	13.75	22.26	17.76
51 - 60 yrs.	14.40	15.24	14.76	15.12	21.24	16.89	22.42	19.32
61 - 70 yrs.	18.84	17.76	18.48	18.72	16.92	21.50	22.51	21.84
Over 70 yrs.	9.36(b)	8.04(b)	8.64(b)	22.32	27.84	22.92	28.99	24.96
TOTAL	10.32	14.88	12.60	12.12	18.12	13.56	19.32	16.32

(a) Restricted eligibility for children under 6 months.
(b) Restricted eligibility for adults over 65 years.

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For males, the highest costs occur among boys under 10 years[1] and men over 50 years; however, for females per capita payments remain fairly consistently high after 21 years.

In Plan A, for example, the average female member cost the plan $14.88 per year for benefits, and the average male cost only $10.32. The average costs to the plan, which are conveniently illustrated in Chart 7, varied from a low of only $7.80 for girls of 2 to 4 years in 1950, to a high of $20.52 for women of 21 to 30 years of age. Men over 50 years of age cost the plan the highest annual averages for males - $14.40 (51 to 60 years) and $18.84 (61 to 70 years); on the other hand, men aged 21 to 40 years required an average of only $9.00 per capita in benefit payments.

The same pattern of costs was experienced under Plan B in 1951. Women in the child-bearing ages receive the highest per capita benefits, while girls between the ages of 2 and 20 years receive considerably less than the average per capita expenditures for all females ($19.32), as shown in Chart 9. Men over 50 years and little boys cost the plan much more than the average cost per male member ($13.56), while males between 11 and 40 years cost much less than the average. Members in the age category 70 years and over have been ignored in this analysis, since they represent only 1 percent of total membership and consequently a reliable average cannot be derived for this group.

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(1) It should be noted that Plan A restricts membership of children under 6 months in some of its contracts.

ADMINISTRATION

In 1952, $2.2 million was spent by all the voluntary non-profit plans for the administration of medical care schemes, amounting to an estimated $1.25 per participant, or 9 percent of income. Since 1949, per capita costs of administration have diminished slightly, as shown in Table 11.

Although on the average, only 9 percent of income was required for purposes of administration, considerable variation is noted among individual plans. As previously mentioned, this percentage is based on an estimate of the proportion of the administration costs of joint medical-hospital benefit plans attributable to their medical care contracts. If the medical plans and medical-hospital plans are considered separately, as in Table 21, the former are estimated to have spent an average of about 9 percent of their income on administration in 1952, while the latter spend 10.5 percent in administering both their hospital and their medical care contracts. It should be noted, however, that administrative procedures and problems vary considerably between plans. A plan which enrolls only employed groups may be able to transfer a large portion of the administrative details to the employers, whereas a plan which enrolls large numbers of subscribers on an individual basis will have many more administrative details to attend to itself. Furthermore, the scope of the contracts being offered, competition for membership, location, coverage, and

other factors all affect the administration costs of each plan. The proportion of income needed for administration in 1952 varied from a low of 6 percent in the B.C. plan, to a high of 16 percent in Alberta and, for the joint plans, from a low of 9 percent in the Quebec Hospital plan to a high of 17 percent in Associated Medical Services. The Maritime Hospital plan, which reported its medical and hospital experiences separately in 1952, spent 15 percent of its medical income on administration, and 9 percent of its hospital plan income.

For every dollar spent on benefits in 1952, the medical care plans spent an estimated average of 10 cents for administration, varying from 6 cents in B.C. to 20 cents in Alberta. The joint medical-hospital care plans spent an average of 12 cents for each dollar in benefits, ranging from 11 cents under the Quebec Hospital plan to 23 cents under Associated Medical Services.

Another measure of the costs of administering medical care benefits is the annual expenditure by the plans on behalf of each member enrolled. The medical care plans spent an estimated average of $1.60 per member on administration in 1952, while the medical-hospital care plans spent about $1.70 per capita in administering their joint medical-hospital operations. Among medical plans, Regina spent about $1.40 and Alberta nearly $2.65 per member. Among

joint plans, the Ontario co-operatives paid out roughly $1.00 per member on administering both medical and hospital benefits while the Associated Medical Services plan paid $2.55 per member for administration. Once again it should be noted that wages and salaries and other prices vary a great deal between different regions of the country, particularly between urban and rural areas, and between different administrative systems.

Between 1949 and 1952, the Saskatoon and Physicians' Services medical care plans, and les Services de Santé, Co-operative Medical Service Federation, and Associated Medical Services medical-hospital care plans, succeeded in reducing their per capita costs of administration, as indicated in Appendix IV.

PAYMENT OF PHYSICIANS' CLAIMS

All physicians providing services to members of non-profit medical plans are paid on a fee-for-service basis. Each plan agrees to pay for services rendered its members on the basis either of a rate-schedule set up by the plan and included in the subscriber's contract, or of the minimum fee schedule established by the provincial medical association concerned. Normally, payment is made directly to the doctor who provides the service, but in certain cases the patient may be reimbursed for a claim which he has paid directly.

Table 21. PER CAPITA EXPENDITURE ON ADMINISTRATION AND PER CENT OF INCOME AND EXPENDITURE ON BENEFITS, NINE MEDICAL INSURANCE PLANS AND FIVE JOINT MEDICAL-HOSPITAL INSURANCE PLANS, RANKED BY SIZE OF ENROLLMENT, 1951

Plan	Administrative Expenditures					
	Per Capita		Percent of Income		Percent of Benefit Expenditures	
	1951	1952[a]	1951	1952	1951	1952
	$	$				
Medical Care Plans						
P.S.I. - Ontario	1.53	1.55	9.2	9.0	11.1	10.8
M.S.A. - B.C.	1.40	1.40	6.7	5.8	7.2	6.3
M.M.S. - Manitoba	1.82	1.89	10.0	9.1	12.0	10.4
M.H.S.A.[b] - Maritimes	1.93	1.54	17.7	14.9	24.9	18.2
W.M.S. - Ontario	1.34	1.45	7.1	7.6	8.3	8.4
M.S.S.I. - Saskatoon	2.21	1.78	13.4	10.3	16.3	12.2
M.M.C. - N.S.	1.72	1.68	10.8	9.8	11.7	11.5
M.S.I. - Alberta	2.26	2.63	13.6	16.2	16.7	20.4
G.M.S. - Regina	1.16	1.38	7.5	9.0	8.4	9.1
Average Nine Plans	1.63	1.61	9.3	8.9	10.9	10.0
Joint Medical-Hospital Care Plans						
Q.H.S.A. - Quebec	1.43	1.65	9.5	9.4	10.9	10.7
M.H.S.A.[b] - Maritimes	1.53	1.73	11.7	10.6	13.0	11.9
C.M.S.F. - Ontario	.98	1.10	12.1	11.3	13.7	13.5
A.M.S. - Ontario	2.96	2.57	21.1	17.4	28.4	23.1
S.S.Q. - Quebec	2.38	2.35	13.7	12.2	15.9	14.2
Average Five Plans	1.55	1.70	11.2	10.5	12.9	12.0

Source: Appendix IV

(a) 1952 per capita figures are estimates, subject to revision.
(b) This plan separates its medical and hospital care accounts in its annual report. Figures given for medical care contracts only apply to 1950 and 1952; for medical and hospital care contracts combined, to 1951 and 1952.

Note: The amounts used for this table as total benefit expenditures represent actual payments to physicians, and not the full amount of allowed claims for medical services received by members.

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None of the plans are responsible for the direct provision of services; they agree only to pay for services which have been received.

As previously mentioned,[1] all of the nine "service" plans enter into contracts with physicians practising as general practitioners who agree to treat member patients, and to accept the fees paid by the plan as full discharge of the members' debts to them. Two of these nine plans offer such a guarantee only to those members whose incomes are below certain specified levels.[2] Specialists, on the other hand, have such agreements with only the Manitoba and British Columbia[3] plans; other specialists may, at their own discretion, charge member-patients extra fees for their services, although in British Columbia and Alberta patients must be informed of such extra charges, if any, before the service is performed. Les Services de Santé du Québec, with a somewhat different approach to this problem, will pay 50 percent of the basic rates set forth in its fee schedule for consulting specialist services. In this plan, contracting specialists agree not to charge extra fees in excess of 50 percent of the basic rates to member patients whose incomes are below the specified limit, when the patients have been referred to them by their family doctors. Low-income members of the Windsor plan are similarly free from extra-billing by specialists.

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(1) See pp. 21-22.
(2) See pp. 36-37.
(3) For referred specialist services only.

The remaining five "indemnification" plans, until 1953, had no such contracts with physicians, and therefore could not guarantee that their members would not be charged additional sums beyond the rates paid by these plans for practitioner services. Four plans have drawn up their own fee schedules setting forth the rates (maximum rates in some cases) which they will pay physicians for specific services performed. Ordinarily these fee schedules form part of the contract issued to subscribers. Practitioners are paid the full rate if the patient's bill is not less than that amount. The Ontario Co-operatives pay physicians and surgeons 100 percent of the rates listed in the Ontario Medical Association Minimum Fee Schedule, but the member is required to meet the first $15.00 of any professional charges out of his own pocket.

Among the nine service plans, those in Manitoba and Quebec have prepared their own fee schedules, on the basis of which contracting physicians submit their claims for services they have rendered. The other plans make use of the respective provincial medical associations' minimum fee schedules, although the two Saskatchewan plans operate on the basis of a special provincial Contract Fee Schedule. Claims submitted by participating doctors are usually first approved or "allowed" by a medical consultant who advises the administrators of each of these service plans. For example, in 1951 under the Windsor plan, 94 percent of the

accounts submitted were approved for payment. But only three plans - the two Saskatchewan plans and the Quebec plan (with the exception noted above regarding specialists) - paid 100 percent of the fees claimed in those accounts which were allowed; the other plans subjected such accounts to a "tax" or discount. Under the British Columbia and Physicians' Services (Ontario) plans, a deduction of 10 percent has been made in the past from each approved claim, in order to cover the costs of administering these plans, and to build up contingency reserves. Both the Manitoba and Maritime Medical plans pro-rate payments to physicians depending on the amount of premium receipts available for making payments in any year. In 1951, doctors' accounts, submitted on the basis of the fee schedules agreed upon, were pro-rated at 72 percent by both of these plans.(1) Similarly the Windsor plan pro-rated allowed accounts in 1951 at 89.9 percent. The Alberta plan has an agreement with the Alberta College of Physicians and Surgeons whereby doctors' accounts, based on the provincial fee schedule, are subject to a discount of between 15 and 20 percent on the average, varying according to the service performed.(2)

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(1) However, heavier pro-rating or discounting does not necessarily result in relatively smaller payments for each service since the fee schedule used is the determining factor in such cases.

(2) In addition, 5 percent of the amounts claimed by Alberta doctors since April 1951 has been "held back" in order partially to overcome a deficit suffered on the previous year's operations.

It would appear that the "pro-rating", "taxing", or discounting of doctors' accounts under the service plans has an effect on the payment of claims very similar to that of the special fee schedules drawn up by the indemnification plans. In the absence of agreements with physicians, the latter plans cannot expect to reduce the claims submitted by doctors to conform to the size of the annual revenues available for distribution to practitioners. Consequently, some of these plans draw up fee schedules which, in effect, have already discounted the rates in the provincial minimum fee schedules which the service plans utilize.

The extent to which pro-rating, taxing, or discounting of doctors' accounts was practised by six of the service plans in 1951 is indicated in Table 22. Three of the plans withheld 10 percent of the fees claimed by practitioners, and three withheld roughly one-quarter of the fees as claimed.

It is of interest to note that over 7,000 practitioners, or more than two-thirds of about 10,450 civilian doctors in independent practice in 1951, had entered into contracts with the nine service plans, either directly, or through their medical associations, whereby they guaranteed to provide general medical care, at no extra cost, to patients who were members of these plans. As Table 23 indicates, almost half of the contracting doctors were in Ontario, and 14 percent in British Columbia. There is undoubtedly some duplication in the figure for Saskatchewan,

Table 22. TOTAL AMOUNTS CLAIMED BY AND PAID TO PRACTITIONERS, AND PERCENTAGE OF CLAIMS PAID, SIX NON-PROFIT MEDICAL INSURANCE PLANS, 1951

Plan	Allowed Claims[a] Based on Fee Schedule	Payments after Pro-Rating	Percent of Claims Paid
	$	$	
Medical Services Association - B.C.	3,613,820[b]	3,252,438	90.0
Physicians' Services Inc. - Ont.	2,722,588	2,450,330	90.0
Windsor Medical Services[c] - Ont.	1,834,323	1,648,294	89.9
Manitoba Medical Services	2,134,714	1,551,951	72.7
Maritime Medical Care - N.S.	725,891	523,035[d]	72.0
Medical Services (Alberta) Inc.	660,595[b]	508,352	77.0

(a) These amounts represent the full amount of allowed claims for services provided by participating physicians, excluding amounts claimed but disallowed due to improper billing.

(b) Estimates.

(c) Comprehensive Control only.

(d) Excluding claims estimated to be owing, but not yet submitted.

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for some doctors enter into contracts with both plans operating in that province.

If the payments for medical benefits made by these nine plans are averaged among the contracting practitioners, it is found that the average doctor under contract received about $1,500 in 1951 through insurance payments from non-profit plans. This is only a rough approximation, of course, since many contracting doctors would treat only a small number of insurance patients. Conversely, some plans pay claims submitted by non-contracting doctors, or by clinics or laboratories for X-ray and diagnostic services. Among the individual plans, doctors under contract with the Windsor plan received an average of $5,346 from the plan, while the lowest average - $450 - was paid to doctors under contract with the Quebec plan.

Table 23. NUMBER OF DOCTORS UNDER CONTRACT, AND AVERAGE ANNUAL PAYMENTS PER CONTRACTING DOCTOR, NINE SERVICE PLANS, 1951

Province	Plan	Contracting Doctors		Average Annual Payments Per Doctor Under Contract
		Number	Per Cent	
				$
British Columbia	MSA	1,041	14	3,124
Alberta	MSI	509	7	999
Saskatchewan		694(a)	10	1,091
	MSSI	429	6	1,331
	GMS	265	4	702
Manitoba	MMS	566	8	2,742
Ontario		3,526	49	1,165
	PSI	3,216	45	762
	WMS	310	4	5,346
Quebec	SSQ	438	6	450
Nova Scotia	MMC	465	6	1,184
Total Seven Provinces		7,239	100	$1,509

(a) This figure contains a certain amount of duplication.

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IV - UTILIZATION OF SERVICES

Any analysis of the experience of prepaid medical care plans should attempt to relate the volume of care received by the membership to the cost of such services. A more rigorous approach would segregate groups of individuals by their enrollment characteristics, particularly length and continuity, and trace their sickness, service, and cost experiences to obtain knowledge of the effects of insurance protection over time. While diagnostic and enrollment information is not available at present to permit this type of analysis, cost and utilization data have been provided by four comprehensive "service" plans, and one "indemnification" plan. This chapter discusses the volume of services rendered to the total membership of the five plans, and the related costs, but due to the limitations of the material provided, volume-cost relationships cannot be presented on an age-sex specific basis.

For a number of reasons, it is not appropriate to compare the utilization experience (volume of services) of these plans. In reporting services received by the members, plans often do not define "services" in the same way; for example, one plan may count an office call each time that a special procedure is performed, while another plan may count only the procedure and not the call. Moreover, particular services are frequently itemized differently by each plan.

Pre-natal services, for example, may be lumped with confinements by one plan, counted as physicians' calls by a second, and itemized separately by a third. Furthermore, the services themselves are not always comparable, for each plan has different waiting-periods, exclusions, and dollar limitations which affect the volume of services provided their members. Also, medical and hospital facilities differ in quantity and organization between communities, and may therefore be expected to affect the volume of each service obtained. Similarly, the nature of the enrolled population may vary considerably between plans, including factors such as the age and sex of members, their urban or rural locations, and their enrollment status as individuals or members of groups. These factors are not taken into account when figures are given for the number of services rendered per capita of total membership. Any comparisons on a per capita basis are therefore questionable. It should be noted that, when waiting-periods apply to some of the services provided by a plan, a large expansion in enrollment in any year renders a considerable portion of the membership ineligible for such services; the number of these services rendered per capita in that year will therefore be unduly low.

In any attempt to apply the utilization experience of the non-profit insurance plans directly to the general population, it must be borne in mind that the groups enrolled

under such plans represent segments of the population specially selected so as to restrict membership to those age groups and employment status groups whose sickness experience is considered insurable.

VOLUME OF SERVICES

Bearing the above limitations on inter-plan comparisons in mind, it may be of interest to examine separately the utilization experience of four of the five reporting plans.(1)

(1) Comprehensive Service Plans

Plan 1 in 1949, its second year of operation, , paid for an average of 2.9 services per member; by 1951 this rate had increased to 3.4 services per member. During this period, Plan 1 expanded its enrollment by over 300 percent. Plan 2, a much older plan with a much slower rate of growth, paid for 4.2 services per member in 1949, 4.0 in 1950, and 4.1 in 1951. Members of Plan 3, many of whom were enrolled on an individual basis, received an average of 2.9 services per member in 1951. Plan 4 paid for an average of 4.0 services to each member under its comprehensive group contract in the same year.

The morbidity rates experienced under most of the plans - that is, the percentage of members receiving medical attention each month - are not available. However, the B.C. plan has stated that its morbidity rate increased from 10 percent in 1949 to 12.5 percent in 1951. Rates reported

(1) A detailed analysis of one of the comprehensive plans is not available.

Table 24. NUMBER OF MEDICAL CARE SERVICES RENDERED PER THOUSAND MEMBERS PER YEAR, AND AVERAGE EXPENDITURE PER MEMBER PER YEAR, BY MAJOR ITEMS OF SERVICE, THREE NON-PROFIT MEDICAL INSURANCE PLANS, 1949-1951

Type of Service	Number of Services Per 1,000 Members Per Year			Average Expenditure Per Member Per Year		
	1949	1950	1951	1949	1950	1951
				$	$	$
Plan 1						
Physicians' Calls	2,375.4	2,470.5	2,787.2	5.37	5.71	7.06
Surgery	140.9	174.7	197.7	4.14	4.35	5.21
Confinements	6.5	10.9	12.6	.30	.48	.64
X-ray, Laboratory & Other Diagnostic Services (a)	121.1	118.6	118.4	.84	.82	.96
Miscellaneous	293.0	384.4	301.5	.67	.90	.76
Total	2,936.9	3,159.1	3,417.4	11.29	12.26	14.64
Plan 2						
Physicians' Calls	3,234.0	3,014.4	3,229.2	6.76	7.30	7.44
Surgery	252.0	242.4	242.4	5.93	5.52	5.53
Confinements	26.4	26.4	25.2	.88	.89	.96
X-ray, Laboratory & Other Diagnostic Services (a)	118.8	127.2	134.4	1.10	1.18	1.32
Miscellaneous	568.8	548.4	519.6	1.16	1.16	1.12
Total	4,200.0	3,958.8	4,150.8	15.84	15.05	16.37

	Plan 3 - 1951	
	Number of Services Per 1,000 Members Per Year	Average Expenditure Per Member Per Year
		$
Physicians' Calls	2,355.5	5.57
Surgery	185.9	4.90
Confinements	33.7	1.59
X-ray, Laboratory & Other Diagnostic Services (a)	257.0	1.24
Miscellaneous (b)	77.9	.27
Total	2,910.1	13.57

Source: Table 27

(a) The utilization rates for this item are considerably influenced by the nature of the contracts and the methods by which the accounts are processed. Plan 1 includes X-rays, B.M.R.'s & E.K.G.'s; Plan 2 includes these items plus cystoscopies; Plan 3 includes a complete range of X-ray, laboratory & diagnostic services.

(b) Many of the items classed as "Miscellaneous" in Plans 1 and 2 were included under other headings in Plan 3.

by the Windsor plan were 18.7 percent in 1949, 17.7 in 1950, and 18.2 percent in 1951.(1) Judging from the experience of these two plans, it would appear that between 1 in 5 and 1 in 8 insured persons obtain some amount of medical care every month.

(a) Physicians' Calls

On the average, each member of Plan 1 received 2.4 physicians' attendances (excluding surgery) in 1949 and 2.8 in 1951, as shown in Table 24. Included in these figures were 1.4 office calls, 0.6 home calls, and 0.3 hospital calls during 1949, with office calls increasing to 1.7 per member in 1951 as Table 27 (see page 152) indicates. Plan 2 paid for an average of 3.2 attendances per member in 1949 and 1951, including 2.1 office calls, 0.6 home calls, and 0.3 hospital calls during 1949, and 2.0 office, 0.5 home, and 0.4 hospital calls in 1951. In Plan 3, operating in a province with more extensive hospital facilities, each member obtained 2.4 attendances during 1951, of which 1.3 were office calls, 0.3 were home calls, and 0.8 were hospital calls.

If miscellaneous items (including injections and refractions) were added to the volume of physicians' attendances paid for under these plans, calls under Plan 1

(1) These rates have not changed significantly in the post-war period, for about ten years ago a rate of 16.8 percent was reported.

would increase to an average of 3.1 per person in 1951, and under Plan 2 to an average of 3.7. The average for Plan 3 would remain unchanged at 2.4 attendances.

(b) Surgical Benefits

The crude rate[1] of surgical services paid for by Plan 1 increased between 1949 and 1951 from 141 to 198 per 1,000 members, largely due to increases in minor surgery; general major surgery remained fairly stable, averaging about 22.5 operations per 1,000 enrollees in both years. Paralleling its stable experience with regard to physicians' calls, Plan 2 experienced only a slight decline in the number of surgical services received by its members; 252 services per 1,000 members were received in 1949, and 242 per 1,000 in 1951, with an increase in minor surgery more than offset by a decrease in the services of anaesthetists. Plan 3 paid for 186 surgical services for every 1,000 members in 1951, including an average of 82 minor surgical operations. These services are shown in greater detail in Table 27, where it can be noted that major surgery, including gynecology, accounted for about one out of every four operations in each plan.[2]

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(1) With no adjustments for age and sex.
(2) Even though the plans probably have different definitions of what constitutes major surgery, such variations would probably not affect this ratio significantly.

(c) Confinements

In considering confinements, it should be noted that a rapidly expanding plan will have a large proportion of members who are ineligible for maternity benefits during the first 9 or 10 months of their membership, in those cases where such waiting-periods are required. As a result, the number of confinements per member will be unduly low. Confinements under Plan 1 increased from 7 to 13 per 1,000 between 1949 and 1951; under Plan 2, which had a much slower rate of growth, they remained fairly stable around 25 per 1,000. An average of 34 confinements per 1,000 members were provided in 1951 under Plan 3, a plan whose policy with regard to waiting-periods for confinements was quite liberal.(1)

(2) Limited Indemnification Plans

The range of benefits offered by the one indemnification plan (Plan 4) which has provided utilization data for this study is more limited than that of the service plans, in that it includes only in-hospital medical services. As would be expected, a much lower volume of services was received by each member of this plan in 1951, as Table 25 shows, than by members of the plans discussed in the previous section. It should be borne in mind that this plan accepts members on a non-group basis.

(1) In all these cases, only the crude confinement rates per 1,000 members have been shown; Plan 2, for example had a rate of 89 confinements per 1,000 females between the ages of 16 and 50 years in 1951.

There has been much speculation by students of medical economics as to the probable effect of hospital care insurance on the demand for medical services. It must be recognized that many other factors than hospital-insurance may have influenced the utilization rates experienced under Contracts A and B of this plan, particularly the age-sex pattern of the membership under each contract. It is striking however, that the crude rates per 1,000 persons for surgery and confinements, for non-surgical hospital calls and for X-ray and diagnostic procedures were all considerably lower in 1951 under Contract B, which did not include hospitalization benefits, (i.e. board and room, and certain auxiliary services) than under Contract A whose subscribers were entitled to hospitalization benefits. However, it would be necessary to know the utilization experience, by age and sex, over a period of time, of the members of several plans with and without hospital insurance before any definite conclusions could be drawn as to the effect of such insurance on the volume of medical care.

Another striking feature of this plan's experience was the decline in the utilization rates for most items of service which occurred when it withdrew its comprehensive service contract ("D") and offered in its place a limited contract ("A") which included increased hospitalization benefits, but which no longer provided home and office care.

Table 25. NUMBER OF SERVICES PER THOUSAND MEMBERS PER YEAR, BY TYPE OF SERVICE, TWO LIMITED INDEMNIFICATION CONTRACTS AND ONE COMPREHENSIVE SERVICE CONTRACT, PLAN 4, 1948 AND 1951.

Type of Service	Limited Indemnification[a] 1951		Comprehensive Service[b] 1948
	A[c]	B[d]	D[e]
Physicians' Calls			
Office	-	-	1178.9
Home	-	-	816.8
Hospital	240.4	186.5	158.3
Night	0.3	-	24.0
Consultations	8.3	9.7	119.9
Total	249.0	196.2	2297.9
Surgery	78.4	67.5	92.4
Surgical Assistants	2.8	2.8	4.6
Anaesthetists	54.6	47.3	71.7
Confinements	32.4	23.6	27.9
X-Ray Diagnostic	40.4	13.9	184.5
X-Ray Therapeutic	16.4	-	21.5
Diagnostic Procedures	3.2	1.4	20.0
Laboratory Procedures	0.3	3.5	16.0
Other Diagnostic	5.3	-	77.0
Miscellaneous	-	-	212.3
Total	482.8	356.2	3025.8

(a) Available only in hospital.
(b) Doctors received full payment for services rendered to members.
(c) Including hospital benefits.
(d) Excluding hospital benefits.
(e) Based on six months' experience (Jan.-June).

As would be expected, the rate for hospital calls increased under the indemnification contract, since services in the home and office were no longer available, while per diem hospital benefits had been increased. The rates for all other items except confinements, however, were considerably reduced following this change, although surgery declined only from 92 to 78 operations per 1,000 members. On the average, the total services per 1,000 members fell from 3,026 services in 1948 under the comprehensive service contract to 483 services in 1951 under the limited indemnification contract which replaced it.

(3) Extended Utilization Experience

It would be valuable to know the volume-cost experience of a plan over a period of years according to the age-sex distribution and length of membership, since continuity of coverage undoubtedly affects the members' demands for service. Unfortunately data for such an analysis are not at present available. However, one comprehensive service plan has provided material concerning the rate of services rendered to total membership over the eight-year period 1944 to 1951, during which period its enrollment increased 15-fold. It seems worthwhile to examine these utilization rates since they illustrate, if only in approximate terms, the behaviour of one of the most important variables in determining a plans' financial experience in any year.

From the information provided, crude utilization rates for selected items of service have been derived, as set forth in Table 26. It may be noted that, over this period, the average annual number of services received by each member increased by less than one service, from 3.3 services per person in 1944 to 4.2 services in 1951, of which over three-fourths consisted of physicians' calls (2.6 in 1944 and 3.2 calls per person in 1951). Of these calls, one-twentieth were hospital attendances in 1944, and one-ninth in 1951. Surgical services on the other hand increased slightly

from 207 per 1,000 members in 1944 to 230 in 1951, but during this period fluctuated between a low of 160 services per 1,000 persons and a high of 278 per 1,000 in 1947 and 1948. In the former year, however, membership increased by 187 percent; therefore a sizeable proportion of the membership became eligible for some items of surgery in 1948 for the first time.

Table 26. NUMBER OF SERVICES PER THOUSAND MEMBERS PER YEAR, BY TYPE OF SERVICE, ONE COMPREHENSIVE PLAN, 1944-1951

Type of Service	1944	1945	1946	1947	1948	1949	1950	1951
Physicians' Calls	2,601.0	2,587.0	2,838.4	2,884.9	3,176.4	3,234.0	3,014.4	3,229.2
Surgery (including Assistants & Anaesthetists)	206.7	183.8	160.5	159.3	278.4	240.0	240.4	230.4
Fractures	7.5	9.7	8.6	8.7	12.0	12.0	12.0	12.0
Confinements	26.5	23.9	31.0	27.8	27.6	26.4	26.4	25.2
X-rays	60.3	68.9	78.2	107.9	115.2	96.0	102.0	108.0
Immunization & Injections	288.6	321.6	389.8	320.3	380.4	382.8	351.6	336.0
Other Services	131.5	176.5	85.6	111.5	164.4	208.8	222.0	210.0
Total	3,322.5	3,371.3	3,592.0	3,620.5	4,156.8	4,200.0	3,958.8	4,150.8
Percentage Increase in Membership	-0.6	17.1	97.3	187.5	44.4	8.1	24.0	13.3

Source: Appendix VII.

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VOLUME AND COST RELATIONSHIPS

The volume of services rendered per person (or the utilization experience of each plan), combined with the price of each particular service, determines the per capita expenditures on services. Therefore, any variation in per capita expenditures between plans is a function of variations in the volume of services of various types rendered per capita and in the prices paid for services in different areas. The rate of services per 1,000 members, the average cost per unit of service (before pro-rating in two cases), and the average annual per capita expenditures on all items of medical care for each of the four reporting plans, are given in Table 27. Changes between 1949 and 1951 in the utilization of services and in the expenditures per capita are given for two of the plans. The average cost per unit of service is included in this table to indicate variations in the price of any particular service between different years or different plans. However, it should be borne in mind that these average figures may not represent the actual payments made for each service, since they may be subject to pro-rating; nor do they represent the exact fees set by provincial medical associations, since such fee schedules include several prices for the same item of service, varying with complications in surgery, or with extra services provided during physicians' calls

It should also be remembered that a plan's ability to balance premium receipts and claims in any year is affected by both its utilization experience and the basis on which prices are established for the services received by its members, usually a provincial fee schedule applicable to both the insured and the non-insured population. As noted earlier, several plans employ pro-rating techniques whereby claims are adjusted proportionately to the available revenues, although in one province the alternative of a specially-developed fee schedule for insurance practice has been adopted.

Although the volume-cost relationships are unique for each plan, for the reasons mentioned previously, one of the striking features of the present analysis is the degree of similarity indicated by the experiences of the plans examined, as illustrated graphically in Chart 10 (see page 157.). The numbers of services rendered per member annually under each of the comprehensive service plans, including Plan 4's comprehensive contract, during the period 1949 to 1951 varied by not much more than about 1 service each, that is, from 2.9 to 4.2 services per member per year. Similarly, the per capita expenditures on services under the three comprehensive plans in 1951 varied by less than $3.00, from $13.57 per capita under Plan 3 to $16.37 per capita under Plan 2. During the eight years to 1951, Plan 2's utilization rate for all services increased by 25 percent

from 3.3 to 4.2 services per person per year, while the average unit cost of each service increased by less than 4 percent; in consequence the expenditure per capita on all services increased by 16 percent, from $14.09 to $16.37.

(1) Physicians' Calls

Per capita expenditures on all physicians' calls in Plan 1 increased by 32 percent, from $5.37 to $7.06 per year (the national average) between 1949 and 1951. This increase resulted partly from an increase in the average number of services provided per member (2.4 to 2.8), and partly from an increase in the average unit cost of these services. In general, increases were experienced under this plan in both the volume and cost of each item of physicians' attendances, with the exception of home calls and consultations. Slight declines in the average cost of home calls, and in the number of consultations provided each member, made for smaller increases in the per capita expenditures on these two items.

Plan 2, which as previously mentioned had a stable volume experience over the three years, with the number of physicians' calls remaining almost unchanged at 3.2 services per member, did experience a 10 percent rise in the average annual expenditure per member, from $6.76 to $7.44 during this period as a result of price increases. Although the per capita volume of office, home, and night calls declined

between 1949 and 1951, increases in the unit cost of each of these services tended to offset the decrease in volume, so that average per capita expenditures on these items changed only slightly. Similarly, an increase in the number of hospital attendances from 0.35 to 0.37 per member was offset by a decrease in the average unit cost of these attendances ($1.82 to $1.76) and therefore annual per capita expenditures thereon remained almost constant at 56 and 59 cents.

Office calls, home calls, and consultations each occasioned less expenditure per member in 1951 under Plan 3 than under Plans 1, or 2, due largely to the lower volume of such services provided per member of Plan 3. However, the average unit costs of home calls and consultations were also lower under Plan 3 than under the other two plans, for it operates in an area where medical prices are at a lower level generally. On the other hand, the average expenditure per member on hospital calls was at least twice as large under Plan 3 as it was under Plans 1 or 2, for more than twice as many hospital calls were provided per member of this plan.

(2) Surgical Services

Under Plan 1, the per capita number of total surgical services[1] increased between 1949 and 1951, including large

(1) Surgical operations, procedures, assistants and anaesthetists. Fee payments for operations usually include pre- and post-operative care, including hospital visits by the attending physician.

Table 27. NUMBER OF MEDICAL CARE SERVICES RENDERED PER THOUSAND MEMBERS PER YEAR, AVERAGE COST PER SERVICE BEFORE PRO-RATING, AND AVERAGE EXPENDITURE PER MEMBER PER YEAR, BY TYPE OF SERVICE, FOUR NON-PROFIT MEDICAL INSURANCE PLANS, 1949-1951

Plan 1

Type of Service	Number of Services Per 1,000 Members Per Year			Average Cost Per Service Before Pro-Rating			Average Expenditure Per Member Per Year		
	1949	1950	1951	1949	1950	1951	1949	1950	1951
				$	$	$	$	$	$
Physicians' Calls									
Office[a]	1419.7	1432.3	1690.3	2.04	2.29	2.53	2.60	2.95	3.85
Home	555.5	573.6	640.9	3.64	3.20	3.46	1.82	1.66	1.99
Hospital[b]	298.9	308.9	313.7	1.65	1.76	1.97	.44	.49	.55
Night	29.6	61.7	49.7	4.29	3.64	4.55	.11	.20	.20
Consultations	49.0	38.3	44.8	7.77	8.62	9.00	.35	.30	.36
Pre & Post Natal	22.7	55.7	47.8	2.21	2.18	2.51	.05	.11	.11
Total	2375.4	2470.5	2787.2				5.37	5.71	7.06
Surgery									
General Major Surgery	22.5	20.2	22.6				1.78	1.88	2.18
Appendectomies	5.9	7.0	6.1	93.34	100.80	102.12	.50	.62	.56
Herniotomies	1.3	2.4	2.6	100.85	109.50	111.72	.12	.24	.26
Cholecystectomies	2.6	1.0	1.3	101.05	144.75	151.03	.24	.12	.18
Other Major[c]	12.7	9.8	12.6	78.96	101.49	103.85	.91	.90	1.18
Gynecology	10.4	8.4	11.0	70.84	79.59	85.39	.67	.60	.84
Minor Surgery	45.0	72.0	88.9				.83	.97	1.10
T. & A.'s	19.9	16.7	20.9	28.14	27.06	27.27	.50	.41	.52
Other Minor	25.1	55.3	68.0	14.58	9.12	9.41	.32	.56	.58
Anaesthetists	53.9	52.2	63.8	12.25	12.75	12.83	.60	.60	.74
Fractures	9.0	8.3	11.3	32.52	38.81	34.41	.26	.29	.35
Total	140.9	174.7	197.7				4.14	4.35	5.21
Confinements	6.5	10.9	12.6	51.43	49.13	55.58	.30	.48	.64
X-Ray, & Diagnostic									
X-Ray Diagnostic	77.4	82.1	89.3	9.50	9.42	10.49	.66	.70	.84
X-Ray Therapeutic	29.3	21.7	18.7	3.51	2.71	3.75	.09	.05	.06
B.M.R.'s	5.6	4.4	3.6	6.36	5.13	5.32	.04	.02	.01
E.K.G.'s	8.8	10.4	6.8	5.44	5.45	7.45	.05	.05	.05
Total	121.1	118.6	118.4				.84	.82	.96
Miscellaneous									
Injections & Immuniz.	170.8	244.7	187.0	1.15	1.12	1.09	.18	.25	.18
Refractions	23.6	38.5	34.6	5.03	4.97	5.45	.11	.17	.17
Other	98.6	101.2	79.9	4.28	5.27	5.64	.38	.48	.41
Total	293.0	384.4	301.5				.67	.90	.76
All Services	2936.9	3159.1	3417.4	4.27	4.31	4.76	11.29	12.26	14.64

(a) Laboratory services, when provided in the office are not counted as separate services.
(b) For non-operative cases.
(c) Includes all other operations having a rate of less than 1 per 1000 members.

Plan 2

Type of Service	Number of Services Per 1,000 Members Per Year			Average Cost Per Service Before Pro-Rating			Average Expenditure Per Member Per Year		
	1949	1950	1951	1949	1950	1951	1949	1950	1951
				$	$	$	$	$	$
Physicians' Calls									
Office	2138.4	1852.8	1950.0	2.10	2.12	2.37	4.01	3.53	4.15
Home	550.8	477.6	547.2	3.04	3.11	3.50	1.50	1.33	1.73
Hospital(a)	345.6	348.0	367.2	1.82	1.75	1.76	.56	.54	.59
Night	62.4	43.2	42.0	3.77	3.91	4.73	.20	.16	.18
Consultations	32.4	32.4	32.4	7.20	7.65	7.83	.22	.23	.23
Extra-Patient	-	27.6	73.2	-	1.04	1.04	-	.02	.07
Annual Medical	26.4	21.6	18.0	4.66	4.97	4.95	.11	.10	.08
Pre & Post Natal	78.0	211.2	199.2	2.18	2.09	2.29	.16	.39	.41
Total	3234.0	3014.4	3229.2				6.76	6.30	7.44
Surgery									
General Major Surgery	26.4	25.2	25.2				2.44	2.32	2.33
Appendectomies	8.4	7.2	7.2	100.43	100.70	101.39	.77	.70	.66
Other Major(b)	18.0	18.0	18.0	-	100.10	104.19	1.67	1.62	1.67
Gynecology	10.8	10.8	10.8				.72	.67	.66
D. & C.'s	4.8	6.0	6.0	25.62	25.02	28.35	.12	.14	.14
Other Gynecology	6.0	4.8	4.8	121.32	127.02	130.07	.60	.53	.52
Minor Surgery	112.8	115.2	120.0				1.37	1.22	1.24
T. & A.'s	32.4	25.2	24.0	25.84	25.88	26.11	.73	.59	.58
Circumcisions	13.2	12.0	12.0	10.54	10.50	10.36	.12	.12	.11
Other Minor	67.2	78.0	84.0	-	7.39	7.31	.52	.51	.55
Surgical Assistants	4.8	1.2	1.2	10.80	10.08	10.07	.05	.01	.01
Anaesthetists	85.2	78.0	73.2	12.59	12.31	13.28	.95	.91	.88
Fractures	12.0	12.0	12.0	36.89	35.68	39.30	.41	.39	.42
Total	252.0	242.4	242.4				5.93	5.52	5.53
Confinements	26.4	26.4	25.2	37.16	37.77	42.19	.88	.89	.96
X-Ray, Laboratory & Diagnostic									
X-Ray Diagnostic	96.0	102.0	108.0	10.56	10.69	10.72	.91	.97	1.04
B.M.R.'s	9.6	9.6	9.6	5.04	5.00	5.02	.04	.05	.05
E.K.G.'s	9.6	10.8	10.8	8.75	8.31	11.40	.07	.08	.11
Other Lab or Diagnostic	3.6	4.8	6.0	23.53	22.92	22.83	.08	.08	.12
Total	118.8	127.2	134.4				1.10	1.18	1.32
Miscellaneous									
Injections & Immuniz.	382.8	351.6	336.0	1.07	1.05	1.11	.37	.34	.32
Refractions	57.6	61.2	52.8	4.31	4.93	5.17	.25	.28	.25
Other	128.4	135.6	130.8	4.69	4.39	4.73	.54	.54	.55
Total	568.8	548.4	519.6				1.16	1.16	1.12
All Services	4200.0	3958.8	4150.8	4.22	4.23	4.39	15.84	15.05	16.37

(a) For non-operative cases.
(b) Includes all other operations having a rate of less than 1 per 1000 members.

Plan 3 - 1951

Type of Service	Number of Services Per 1000 Members Per Year	Average Cost Per Service	Average Expenditure Per Member Per Year
		$	$
Physicians' Calls			
Office	1257.0	2.38	3.00
Home	282.4	2.88	.82
Hospital(a)	753.9	1.86	1.40
Night	45.4	4.95	.22
Consultations	16.8	7.64	.13
Total	2355.5		5.57
Surgery			
General Major Surgery	21.9		2.01
Appendectomies	9.7	83.20	.81
Herniotomies	2.7	85.58	.23
Cholecystectomies	1.9	124.68	.23
Other Major(b)	7.7	96.19	.74
Gynecology	11.0		.67
D. & C.'s	5.9	28.77	.17
Hysterectomies	1.1	119.53	.14
Other Gyn.	4.0	90.63	.36
Minor Surgery	82.0		1.18
T. & A.'s	18.6	30.37	.56
Hemorrhoidectomies	1.8	37.93	.07
Other Minor	61.7	8.93	.55
Surgical Assistants	12.2	14.83	.18
Anaesthetists	46.9	12.20	.57
Fractures	11.8	24.68	.29
Total	185.9		4.90
Confinements	33.7	47.07	1.59
X-Ray Laboratory & Diagnostic			
X-Ray Diagnostic	95.0	8.03	.76
X-Ray Therapeutic	5.1	9.48	.05
B.M.R.'s	9.1	5.06	.05
E.K.G.'s	7.1	7.04	.05
Laboratory Services(c)	130.6	1.52	.20
Other Diagnostic	10.1	13.55	.74
Total	257.0		1.24
Miscellaneous			
Injections & Immuniz.	47.6	3.46	.16
Other	30.3	3.63	.11
Total	77.9		.27
All Services	2910.1	4.67	13.57

(a) For non-operative cases.
(b) Includes all other operations having a rate of less than 1 per 1000 members.
(c) Including Lab. Services provided during office calls at the rate of 98.4 per 1000 members per year.

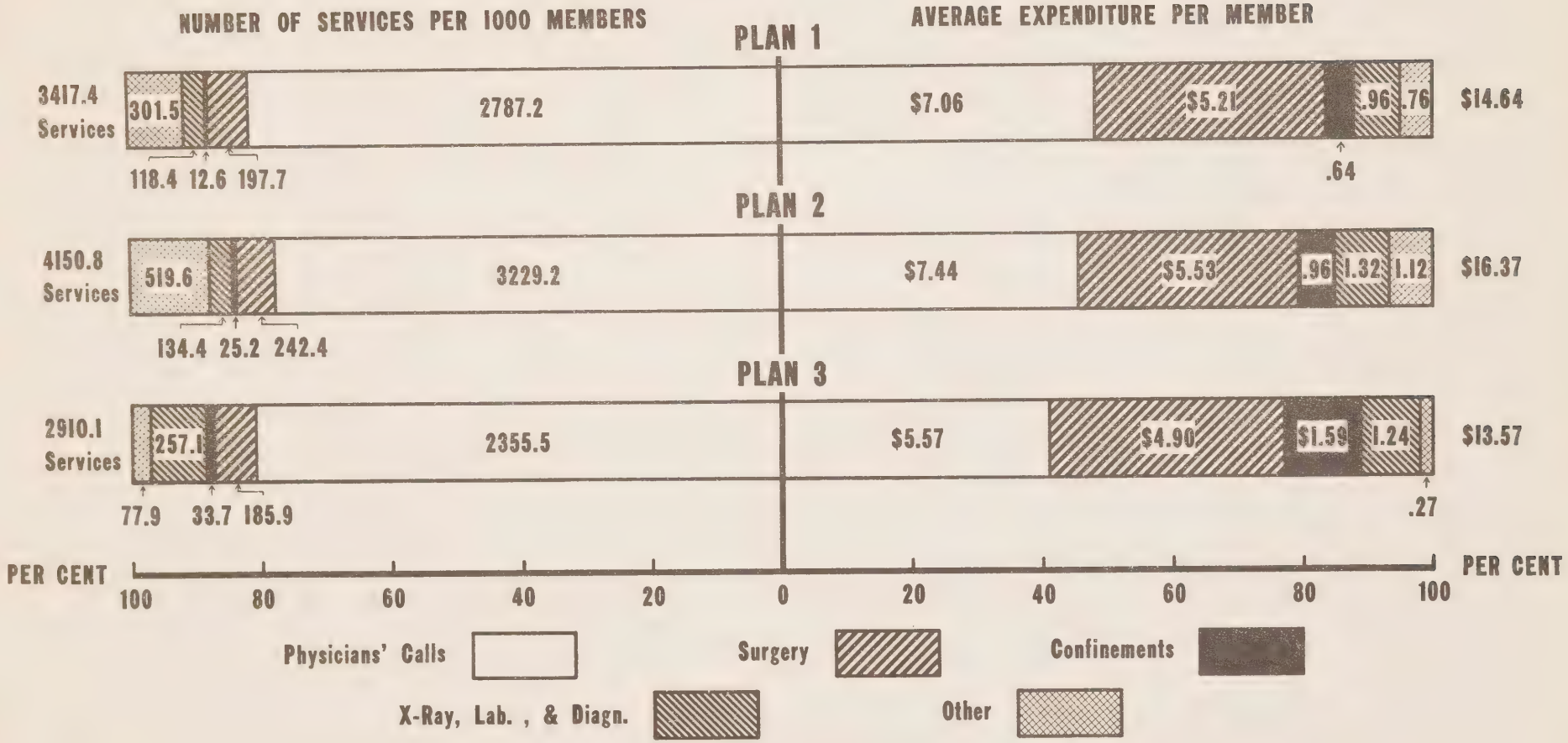
Type of Service	Number of Services Per 1000 Members Per Year			Average Cost Per Service			Average Expenditure Per Member Per Year		
	Contracts			Contracts			Contracts		
	A	B	C	A	B	C	A	B	C
				$	$	$	$	$	$
Physicians' Calls[a]									
Hospital[b]	240.4	186.5	239.1	1.84	1.69	2.04	.43	.31	.48
Night	0.3	-	-	4.56	-	-	-	-	-
Consultations	8.3	9.7	4.4	6.38	10.29	8.51	.06	.10	.04
Total	249.0	196.2	243.5				.49	.41	.52
Surgical Benefits									
Surgery[c]	70.2	62.6	71.1	41.27	46.13	44.28	2.89	2.88	3.13
Hysterectomies	2.2	1.4	1.8	118.22	125.00	109.83	.25	.17	.19
Caesarean Sections	1.6	-	0.4	78.41	-	85.00	.12	-	.04
Other Female Surgery	4.4	3.5	3.7	41.36	32.00	37.25	.17	.10	.13
Surgical Assistants	2.8	2.8	6.6	23.13	28.75	13.17	.06	.07	.10
Anaesthetists	54.6	47.3	49.0	12.34	12.57	12.61	.66	.58	.61
Total	135.8	117.6	132.6				4.15	3.89	4.20
Childbirth									
Miscarriages	2.7	1.4	1.6	27.76	22.50	26.97	.07	.04	.04
Confinements	29.7	22.2	13.5	55.24	59.86	49.48	1.63	1.33	.66
Total	32.4	23.6	15.1				1.70	1.37	.70
X-Ray and Diagnostic									
X-Ray Diagnostic	40.4	13.9	21.7	8.69	11.34	6.95	.34	.14	.14
X-Ray Therapeutic	16.4	-	16.3	5.24	-	3.92	.08	-	.06
Diagnostic Fee (Surgery)	0.07	-	0.03	25.00	-	13.50	-	-	-
Diagnostic Procedures	3.2	1.4	4.7	13.60	10.00	12.46	.05	-	.06
Laboratory Procedures	0.3	3.5	0.13	11.33	2.50	21.63	-	-	-
Blood Counts	-	-	0.016	-	-	31.00	-	-	-
E.K.G.'s	4.1	-	1.8	5.31	-	4.76	.01	-	-
B.M.R.'s	0.18	-	0.2	4.50	-	4.85	-	-	-
Biopsies	0.26	-	0.4	39.64	-	24.71	-	-	-
Other	0.66	-	0.28	7.90	-	9.38	-	-	-
Total	65.6	18.8	45.6				.48	.14	.26
Injections	-	-	0.016	-	-	15.00	-	-	-
	482.8	356.2	436.8				6.97	5.82	5.80

(a) Home and Office calls not provided.
(b) For non-operative cases.
(c) Includes all major and minor surgery except female surgery.

Note: This plan, unlike Plans 1-3, indemnifies members for the medical charges they have incurred.

increases in minor surgery, and slight increases in most of the items of major surgery, except cholecystectomies. Over the same period, the payments made per unit of major surgery increased considerably, while the costs of minor surgery decreased. In consequence, the average annual expenditure per member on every item except cholecystectomies increased, with an overall increase in all items of surgery of 26 percent, from $4.14 to $5.21. On the other hand, although there were slight increases in the unit costs for most of these services under Plan 2, the rate of surgical services per thousand declined sufficiently to reduce the per capita expenditures by almost 7 percent over this period, from $5.93 to $5.53. In 1951, the per capita expenditure on surgical services under Plan 3 was lower than that under both Plans 1 and 2 ($4.90 per year, as compared with $5.21 and $5.53) due to the fact that both the volume of such services per capita and the average unit cost of services were lower under this plan. Of course, the per capita volume of surgical services provided under Plan 5's three indemnification contracts, and therefore the average expenditure per capita, were lower than under the comprehensive plans, largely because these three limited contracts imposed more restrictions on the medical benefits available to their members.

NUMBER OF SERVICES RENDERED PER 1000 MEMBERS, AND AVERAGE EXPENDITURE PER MEMBER, BY MAJOR ITEMS OF SERVICE FOUR COMPREHENSIVE SERVICE PLANS, 1951



Source: Table 24

(3) Surgical Operations Ranked According to Frequency

As mentioned in the previous chapter,[1] appendectomies, tonsillectomies and fractures, in that order, were the largest single items of per capita surgical expenditure in Plans 1, 2 and 3 in 1951. But, in terms of the rate of surgical operations performed, appendectomies dropped to third place[2] in each of the plans, as shown in Table 27. The higher cost of appendectomies under all three plans accounts for the greater per capita expenditure on this type of operation. In fourth, fifth, and sixth place in the rate of operations provided are D. & C.'s (dilatation and curettage), herniotomies and cholecystectomies. But since the prices of these last two operations were much greater than the price of D. & C., the latter fell to sixth place in size of expenditures per capita.

The effect of the application of insurance principles to the problems of so-called "castastrophic" medical care costs is forcefully illustrated in Table 28, which shows the combined experience of four plans in paying for the eight items of surgical care most frequently obtained by their members in 1951. Payments for high-cost operations such as cholecystectomies and hysterectomies, when spread over the insured population, accounted for a very small

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(1) See p.107.

(2) In Plan 2, circumcisions and fractures both occupied second place with regard to the number of services provided.

Table 28. NUMBER OF OPERATIONS PER THOUSAND MEMBERS PER YEAR, AVERAGE COST OF EACH OPERATION BEFORE PRO-RATING, AND AVERAGE EXPENDITURE PER MEMBER PER YEAR, THE EIGHT MOST FREQUENT ITEMS OF SURGERY, FOUR NON-PROFIT SERVICE PLANS, 1951

Ranked Surgical Operations	Number of Services Per 1,000 Members Per Year	Average Cost Per Service (Before Pro-Rating)	Average Expenditure Per Member Per Year
		$	$
Tonsillectomies and Adenoidectomies	20.3	28.32	.50
Fractures	12.1	28.96	.31
Appendectomies	7.7	105.55	.69
Dilatation and Curettage[a]	4.7	31.29	.13
Herniotomies[a]	2.5	108.17	.23
Cholecystectomies[a]	1.6	149.39	.20
Hemorrhoidectomies[b]	2.0	43.29	.07
Hysterectomies[b]	1.4	139.05	.15

(a) Information from three plans only.
(b) Information from two plans only.

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proportion of the plans' total benefit expenditures. Yet for the individual non-insured patient, such items of medical care would constitute a serious incursion into the family budget, particularly when the doctor may charge rates above the minimum fee schedule. On the other hand, low-cost items such as tonsillectomies and fractures, which might reasonably be met out of most family budgets, represent quite a high proportion of the plans' surgical expenditures, due to the high frequency of occurrence of these conditions. Appendectomies, however, which combine high costs and high volume, constitute a serious item of expenditure for both individual non-insured patients, and prepayment plans. In general, then, most high-cost operations, though expensive for the individual patient, represent a small part of the total problem of financing medical care insurance. It is the relatively low-cost items with high incidence rates which constitute the major part of this problem.

(4) Dollar Limitations on Surgical Benefits

It was noted in Chater II[1] that certain indemnification plans limited payments for surgical benefits to a maximum of $150 or $200 per operation. If it is assumed that the rates of services received and the unit costs of these services under indemnification plans are comparable to the above data for service plans, it would appear that this particular limitation does not restrict the payments for those surgical operations most frequently required by members, for it will be noted from Table 27 that the average cost of each of the eight most frequent operations (except cholecystectomies under Plans 1 and 4, in 1951) was less than $150. An examination of the fee schedule of one provincial College of Physicians and Surgeons indicated that those operations which cost more than $200 include only the less frequently occurring ones - for example, total hysterectomies, radical prostatectomies, thyroidectomies, gastrectomies, radical mastectomies, nephrectomies, pneumonectomies, and cerebral tumours. Using a 1948 United States Blue Shield study as a rough guide, it appears that, with the exception of hysterectomies, none of these operations occurred more frequently than five times per 10,000 members in a year, whereas tonsillectomies were performed 139 times, appendectomies 56 times, herniotomies 18 times, and cholecystectomies 11 times, per 10,000 members per year.[2]

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(1) See p.54.
(2) U.S. Senate, op. cit., Part 2, p. 45.

From the member's point of view, a more important limitation is the fact that the payments allowed by an indemnification plan are usually less than the minimum fees set by the doctors. A comparison of the payments for 64 items of surgery, as set forth in the 1952 contract schedule of one indemnification plan, with the minimum fees established in the same year by the College of Physicians and Surgeons in that province, shows that for 55 of these items, plan payments were lower than the minimum fees - $10 to $25 lower on the less expensive items, and $50 to $350 lower on the more expensive items of surgery. This feature is based on the previously-noted principle, common to all indemnification plans, that the insured person should retain responsibility for assuming some portion of his medical care expenses. Considering only the seven surgical services most frequently received by members (excluding the collective item "fractures"), Table 29 indicates that this situation holds for these services as well, with the exception of confinements, tonsillectomies in children, and simple appendectomies. The percentage of the minimum fee assumed by the patient varied from one-third in the case of acute appendectomies to two-thirds in the case of D. & C.'s. It should be noted that these are "minimum" fees, and that individual surgeons may charge more than these amounts at their discretion.

Table 29. MINIMUM AMOUNT AND PERCENTAGE OF FEE ASSUMED BY PATIENT, BASED ON MINIMUM FEE SCHEDULE OF PROVINCIAL COLLEGE OF PHYSICIANS AND SURGEONS, SEVEN SELECTED ITEMS, ONE "INDEMNIFICATION" PLAN, 1952

	Minimum Assumed by Patient	
	Amount	Percentage
	$	
Confinements	0	0
Tonsils and Adenoids		
Children under 12	0	0
Persons 12 and over	25	41.7
Appendectomy		
Simple	0	0
Acute with peritonitis	50	33.3
Dilatation and Curettage	50	66.7
Herniotomy		
Single	50	50.0
Double	75	50.0
Hemorrhoidectomy	35	46.7
Hysterectomy		
Sub-Total	100	50.0
Total	100	40.0

(5) Volume and Cost by Sex

Although it was not possible in the above analysis of physicians' calls and surgical services to give a simultaneous age-sex distribution of the services provided, the volume and cost of each type of service for males and for females in 1953 was provided by a fifth plan regarding its comprehensive group contract. The figures shown in Table 30 relate only to adults enrolled under two-person or family contracts; thus the rates of service shown do not reflect the service demands made by single individuals. Furthermore, these rates are not given in age-sex specific terms, and may have been considerably influenced by an atypical age distribution of the members of either sex, as compared to the distribution to be found in a normal population.(1)

The most striking feature of the distribution of services by sex is the fact that the per capita volume of services received by females was considerably greater than the rate for males on physicians' calls, surgical procedures, and X-ray, diagnostic, and other miscellaneous services.

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(1) An age-sex comparison of the adult covered population with, for example, the population of the largest city in which the plan operates cannot be made. However, the age-sex distribution of the adult members under these contracts for June 1952 indicates that females (8,275) exceeded males (5,572) by nearly 50 percent in the age group 20-30 years, and by about 23 percent in the age group 20-40 years. Males 41 years and over however exceeded females by 36 percent; those over 66 years, by over 90 percent.

Table 30. NUMBER OF MEDICAL CARE SERVICES RENDERED PER THOUSAND MEMBERS PER YEAR, AND AVERAGE EXPENDITURE PER MEMBER PER YEAR, BY TYPE OF SERVICE, AND BY SEX, UNDER COMPREHENSIVE GROUP CONTRACT, ADULT FAMILY SUBSCRIBERS, PLAN 5, 1953

Type of Service	Number of Services Per 1000 Adult Members Per Year		Average Expenditure Per Adult Member Per Year	
	Males	Females	Males	Females
			$	$
Physicians' Calls				
Office	1923.0	2897.3	6.47	9.87
Home	331.4	523.6	1.35	2.11
Hospital	342.0	472.5	1.03	1.34
Consultations	26.5	35.3	.32	.40
Medical Treatments	8.2	5.6	.02	.02
Medical Examinations	126.2	152.2	.80	.95
Total	2757.3	4086.5	9.99	14.69
Surgery				
Appendectomy	5.5	4.9	.68	.61
Caesarian	-	1.3	-	.18
Cholecystectomy	1.1	4.4	.17	.72
Cystoscopy	4.6	4.8	.11	.10
Fract. Rad. & Ulna.	.7	1.5	.03	.06
Tib. & Fib.	.6	.6	.03	.03
Gynaecology - D & C	-	11.2	-	.45
Hysterectomy	-	4.4	-	.69
Hysteropexy	-	1.1	-	.12
Salpingectomy & Oophorectomy	-	3.0	-	.40
Colpoplasty	-	2.0	-	.28
Cervix Cautery & Conization	-	2.6	-	.11
Hemorrhoidectomy	2.3	2.8	.11	.13
Hernioplasty	5.3	2.2	.60	.29
Strabismus	.2	.1	.03	.01
Thyroidectomy	.3	2.0	.06	.32
T. & A	2.4	3.4	.07	.11
Traumatic Wounds	6.8	3.9	.07	.03
Tumors - Benign Breast	.2	4.5	.01	.18
Vein Ligation	1.0	2.7	.06	.15
All other surgery	124.1	131.7	3.41	3.43
Surgical Assistants	2.6	4.1	.09	.14
Anaesthesia	14.3	27.8	.21	.38
	172.0	227.0	5.74	8.92
Confinements	-	84.1	-	6.93
Ancillary Benefits				
X-Ray Diagnostic	319.3	356.7	3.74	4.10
X-Ray Therapeutic	18.4	32.2	.10	.18
Laboratory	374.3	715.3	.71	1.13
BMR	16.1	68.5	.08	.32
EKG	57.1	31.7	.49	.28
Miscellaneous Services				
Immun. & Injections	110.8	186.1	.26	.47
Refractions	72.5	95.9	.71	.94
Allergy	18.6	25.2	.09	.13
	987.1	1511.6	6.18	7.55
All Services	3916.4	5909.2	21.91	38.09

Note: The above average expenditure figures represent claims submitted by practitioners at 100 percent of the fee schedule, and do not represent actual payments to doctors.

However, in particular cases such as medical treatments, electrocardiograms, and operative procedures for herniotomies, appendectomies, and traumatic wounds, the rate for males exceeded that for females. On the average, each female member received a total of six services per year, while each male member received less than four. Males received about two-thirds as many physicians' calls, major surgical procedures, X-ray and laboratory services, and miscellaneous services as females.

Similarly, the average cost of physicians' calls and surgical services for males was about two-thirds that for females - $9.99 and $14.69 per capita for physicians' calls and $5.74 and $8.92 for surgery. The over-all claims against male members were slightly more than half the claims against females - $21.91 per adult male and $38.09 per adult female. Of course, the higher per capita cost for females is partly accounted for by the average charges for gynaecological operations ($2.23 per capita) and deliveries ($6.93 per capita). If children and single persons under Plan 5 are combined with the adult males and females in this analysis, the average volume of services would be 4.5 services per member annually, and the average claims $25.37 per member per year, as compared with the annual averages for adult males and females of 4.7 services and $29.47 per member.

V - CONCLUSION

COVERAGE

Non-profit medical insurance plans had enrolled 2.4 million persons, or 16 percent of the total Canadian population, for some form of medical insurance benefits by 1953. Not included in these figures are persons subscribing to commercial insurance company plans, nor the limited number under co-operative plans in British Columbia and the Maritimes, nor those receiving health services directly from their employer. No information is at present available regarding the proportion of these persons who were also included among those covered by commercial sickness insurance plans in 1953.(1) Coverage under non-profit plans by provinces ranged from 6 percent of Alberta's total population to 21 percent of the people in Manitoba.

Of the fourteen plans covered by this study, nine are "service" plans, guaranteeing to pay the full cost of any general practitioner services rendered to members by doctors under contract with the plans, and five are "indemnification" plans which do not enter into contracts with doctors, but which agree to reimburse members for their medical expenses up to certain fixed amounts for each type of service. Fifty-one percent of those covered in Canada

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(1) It has been estimated that over 2.3 million persons were covered for surgical benefits in 1952 under commercial insurance company contracts, and that about one-sixth of these were also covered under non-profit or other commercial contracts.

were enrolled with service plans in 1953, whereas 67 to 75 percent of American Blue Shield enrollees were covered under indemnification contracts (1951).

(1) Types of Contract

"Comprehensive" contracts have been defined in this bulletin as those providing a wide range of medical benefits, including doctors' calls in home and office, specialist consultations, and x-ray and laboratory services, as well as medical, surgical and obstetrical care in hospital. In 1951, 5.3 percent of the total population or 47 percent of the enrolled population were covered under such contracts. In contrast, 2.4 percent of the total United States population or 14 percent of enrolled persons had comprehensive coverage in the same year. By 1953, 7.5 percent of the Canadian population were enrolled for comprehensive benefits. Other contracts which provide surgical and obstetrical care, with or without medical (non-surgical) care in hospital, have been defined as "limited" contracts. Six percent of the Canadian population were covered under such contracts in 1951 and 8.5 percent in 1953, including all persons enrolled in the five indemnification plans.

(a) Comprehensive

The comprehensive service plans pay the complete cost of all necessary preventive, diagnostic, therapeutic, or consultative services performed by general practitioners in home, office and hospital on behalf of

member patients. However, members may be charged extra sums by specialists providing treatment or consultations under all the comprehensive plans except Manitoba Medical Service.(1) The extent to which such "extra-billing" is actually practised is not known. It is known, however, that subscribers below stated income levels in the Windsor and S.S.Q. plans are not subject to extra-billing.

Ancillary benefits, such as x-ray, laboratory and other diagnostic services are available to a majority of the comprehensively-insured persons without limitation, although a few contracts set maximum sums which will be paid for such services. A majority of these persons are also eligible for surgery and for treatment for pre-existing conditions as soon as they enroll. To meet the problem of proportionately high rates of confinements per thousand enrollees, all of the plans have imposed waiting periods of at least nine months on almost all insured persons before they become eligible for obstetrical benefits.

(b) Limited

Persons insured under "limited" contracts are entitled to surgical and obstetrical benefits, usually after undergoing waiting periods of from 6 to 12 months, and almost nine-tenths of them were entitled in 1953 to

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(1) The B.C. Medical Services Association, to the extent that it meets the full cost of any necessary referred specialist care, should also be excepted.

non-surgical medical care in hospital. Of the 1,249,000 Canadians enrolled under these contracts in 1953, one-half were in the province of Quebec, and 92 percent were covered under indemnification plans It is of interest to note that at least 92 percent of persons with limited medical insurance were also insured for hospital care benefits in 1953 through non-profit plans.

The limited contracts do not cover home and office calls. For the majority of insured persons, non-surgical care in hospital is limited to $3 per day or one call per day for a maximum of from 31 to 51 days per admission, or per year. Surgical and obstetrical benefits are also subject to dollar limitations in most cases. Unrestricted consultant services (usually referrals to specialists) are available to only a relatively small number of persons with limited insurance - four percent in 1951 - and the majority (78 percent in 1951) are not entitled to any consultant services. Limited laboratory and x-ray services are provided under hospital care contracts to over four-fifths of persons insured under limited medical care contracts.

(2) Enrollment

The great majority of the insured population today are enrolled under group contracts, usually based on employment, but occasionally on membership in a credit union or service club, or on residence in a municipality; the

remainder are enrolled on an individual basis (about four percent in 1951). Although elderly persons are usually barred from joining non-profit plans, either by direct age limits or by the employment requirement, most plans do not require that new applicants be in good health, and none of them exclude higher-income recipients from membership.

FINANCES

It has been estimated that the non-profit, co-operative and commercial medical insurance plans in 1952 provided between 17 and 19 percent of total payments to physicians from all sources. Of this amount the non-profit plans spent about $20.7 million or $11.85 per insured person. The service plans paid out an average of $16.70 and the indemnification plans $6.75 per member. Among the eight doctor-sponsored service plans an average of 88 cents out of each income dollar was spent on medical benefits, 8 cents on administration and 4 cents was placed in reserve.

Physicians' calls accounted for 44 percent of the medical benefit expenditures under the comprehensive contracts offered by eight service plans in 1951, surgery for 35 percent (including anaesthetists), confinements for 6 percent, and x-ray, laboratory and other services for 15 percent of this total. Home and office calls alone amounted to 38 percent, or about $6 per insured person, while all services together cost these eight plans an average of $16.02 per person in 1951. Among the various items of surgery paid for

by the plans, appendectomies, tonsillectomies and fractures were the three largest single items of expenditure. These items were also the three largest single items of surgery in terms of the volume of operations performed.

METHODS OF PAYMENT

As mentioned, the service plans are distinguished by the fact that they enter into contracts with general practitioners who agree to accept plan payments as full discharge of their claims against member-patients. However, contracting specialists, except under the Manitoba and British Columbia(1) plans, are not so bound, and may charge patients more than the scheduled minimum fees. More than two-thirds of the civilian doctors in independent practice in 1951 had entered into such contracts. In six of the doctor-sponsored plans, the claims submitted by practitioners in 1951 were discounted (or pro-rated) at rates varying from 10 to 28 percent of total claims, depending upon the funds available to meet these costs.

UTILIZATION

Although the national experience with regard to the volume of services obtained by insured persons in 1953 is not known, the average number of services per beneficiary under comprehensive contracts covering 416,000 persons in four

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(1) To the extent that necessary referred specialist care is paid for by the plan.

service plans in 1951, varied from 2.9 to 4.2 services per member, including 2.3 to 3.2 physicians' calls. Surgical services ranged from 186 to 242 services per thousand members and confinements from 13 to 34 per thousand. Of the eight items of surgery most frequently received by members of all four plans, tonsillectomies at 20 per thousand members ranked first and 1.4 hysterectomies per thousand last.(1) Most high-cost operations, though expensive for the individual patient, were found to represent a small part of the total problem of financing medical care insurance. The relatively low-cost items with high incidence rates constitute the major part of this problem.

SPECIAL PROBLEMS

Because of the geographic, economic and social diversity of the Canadian population, there are several special problems which affect the operations of the non-profit plans, including, among others, the extension of coverage to a larger proportion of the population, and the provision of continuity of coverage for persons moving from one province to another.

(1) Extension of Coverage

To ensure financial stability of their operations, the medical insurance plans attempt to achieve wide coverage of the population in order to spread the insurance risks

(1) These rates have not been adjusted for the age and sex of the population.

over as broad a base as possible. However, about 15 percent of the labour force in 1951 were self-employed businessmen, farmers or others working on their own account; these, together with persons in small firms, were not able to enroll under the 16 (out of 30) medical insurance contracts offered to employed groups only. Four of the plans have introduced individual or community contracts in an attempt to extend their coverage to these classes, and four others will enroll members of credit unions or service clubs. But most of the insured population in 1951 (about 80 percent) were covered under employed group contracts, which together had enrolled between 20 and 25 percent of the non-agricultural wage-earning population.

(2) Continuity of Coverage

Since a portion of the Canadian labour force is highly mobile, shifting from one industry to another, or from one province to another(1), the problem of providing continuity of coverage, although a relatively small one, is exceedingly important to the persons concerned. Most of the plans arrange to continue membership on a direct payment basis for enrollees who shift out of covered employment within the province; however, the matter of continuing coverage for those members leaving the province is more

(1) Between June 1952 and June 1953 it is estimated that 143,000 persons or 1 percent of the total population left the province in which they had been residing to take up residence in some other part of Canada.

complex, and involves inter-plan relationships complicated by the variations in the pattern of benefit contracts available and in the price levels for medical services in different parts of Canada.

TRANS-CANADA MEDICAL PLANS

A growing awareness by the Canadian people of the value of medical care insurance, together with rising standards of living and expanding industrialization, have led to the inclusion of prepaid health programs in employer-employee bargaining agreements, as well as increasing demands for coverage from new sections of the public. The demands made upon the medically-sponsored plans for programs of coverage for national employers with employees in several provinces involved the development of arrangements beyond the constitutional ability of these individual plans. They recognized that these demands constituted a further national problem, in addition to the provision of continuity of coverage, for which some new organizational arrangement would have to be created.

The initial attempt to answer these problems on the part of the doctor-sponsored plans, in co-operation with the Canadian Medical Association, was the decision to establish a nationwide plan under federal charter with uniform benefits

and uniform rates.(1) However, action on this proposal was discontinued in 1951 because of the diversity of problems which the non-profit plans had to face in their respective areas, and the difficulty of setting a flat-rate premium which would be equally satisfactory in high-cost and low-income areas.

In addition to the differences in the economic and social characteristics of the various provincial populations, including attitudes toward illness and the methods employed to alleviate it, the constitutional and practical considerations involved indicated the need for the maintenance of locally-administered schemes under provincial incorporation. Instead of a single, national plan, therefore, there was set up in June, 1951 by seven of the doctor-sponsored plans,(2) a body known originally as "Trans-Canada Medical Services" (TCMS), under the sponsorship of the Canadian Medical Association. This body, whose original members had at that time a combined membership of about 670,000 persons, was to be a co-ordinating body and would itself sell no contracts

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(1) Three contracts, including a comprehensive one at $71 per year, a surgical benefit contract at $28 per year, and a surgical, obstetrical and medical-care-in-hospital contract at $37 per year for a subscriber with more than one dependent, were proposed in 1951.

(2) The seven charter members were Maritime Medical Care, Physician's Services Inc. (Ontario), Manitoba Medical Service, Group Medical Services, (Regina) Medical Services Saskatoon Inc., Medical Services (Alberta) Inc., and Medical Services Association.(B.C.).

to the public but would serve only as an agency of its autonomous members. In addition to working out satisfactory inter-plan relationships to meet the problems of mobility of population and the development of co-ordinated coverage for national employers, it would also undertake to serve as an agency for the exchange of information in such matters as enrollment, operating procedures, the development of adequate statistical information and other research and promotional activities, and, in general, carry out such other objectives on behalf of the member plans as would assist their development and their ability to provide coverage to an ever-increasing percentage of the population.

Early in 1953 TCMS changed its name to "Trans-Canada Medical Plans" (TCMP), to indicate that it was not a new, nationwide plan but an association of previously-existing plans organized under a co-ordinating body similar to the United States Blue Shield Commission.(1)

The members of TCMP established an Inter-Plan Transfer arrangement for the provision of continous coverage to those persons who transfer from one section of the

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(1) Voting membership had previously been restricted to plans designated by the provincial medical associations as their representatives in each province. In 1953 such membership was extended to any plan "sponsored, endorsed, approved or designated by a provincial medical association as a plan acceptable to its standards", which had written participating agreements with at least 51% of the licensed medical practitioners in the areas in which it operates. As a result, the Windsor, Quebec Hospital, and Maritime Hospital Plans were all admitted to voting membership in 1953. By July 1953, TCMP's member plans covered about 1.9 million persons.

country to another. All member plans which accept the Inter-Plan Transfer Agreement agree to cancel the constracts of subscribers who move into the area served by another participating plan, and to accept as members all paid-up subscribers of other participating plans who apply for transfer. The actual transfer becomes effective on the day following the paid-up date shown on the transfer form (usually three months after notice of change of address has been received by the original plan), and the plan to which the subscriber is transferring becomes responsible for medical benefits received by the subscriber after that date. Continuous prior membership in another plan is credited towards any waiting periods that may be required by the plan to which transfer is made. By February 1954, this agreement had been approved by all member plans except the B.C. Medical Services Association.(1) It should be pointed out, however, that most of the plans had previously made their own informal arrangements for transferring members to and from other plans in Canada; these have now been standardized under either Trans-Canada Medical Plans or the Canadian Council of Blue Cross Plans.

A standardized limited-benefit contract for national industrial employers was also agreed upon by the members of T.C.M.P., but, as of February 1954, had not yet been made

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(1) The B.C. plan intends to incorporate a subsidiary plan in 1954 to handle contracts transferred from TCMP and U.S. Blue Shield Plans, as well as conversions from its own group contracts.

available to employers. Plans in the three western provinces have introduced, or are introducing, limited benefit contracts of a generally similar nature. At the same time the two plans in the east not at present providing comprehensive coverage have such programs under consideration with a view to early introduction. When these arrangements have been completed, national industrial employers will have a choice between a comprehensive and a limited medical contract for their employees in any province.

THE COSTS OF INSURANCE

The demand for medical care insurance is a function of a number of variables, including the prices charged for insurance contracts and the incomes of potential members, or their ability to pay for such insurance. In 1952 a Canadian family of husband, wife and two children would have had to spend an average of $68 to buy comprehensive medical insurance, ranging from $51 under the Regina plan to $84 under the Manitoba non-group plan. The provincial variation in scales of living is roughly indicated by the fact that the proportion of wage-earning families where the head of the family earned less than $2500 in 1951 varied from 50 percent in Ontario to 75 percent in the Atlantic provinces, and amounted to 56 percent for the whole of Canada.(1) It

(1) Dominion Bureau of Statistics, Ninth Census of Canada, 1951. Family Size and Type, and Earnings of Head, Bulletin 3-1, Vol. III, (Ottawa: Queen's Printer, 1952), Table 128.

should be noted, however, that family incomes in some cases would be higher than the amounts reported in the Census, since an estimated 10 percent of married females were engaged in non-agricultural employment in 1951. It is also significant that the Canadian Sickness Survey in 1950-51 found that, although 8 percent of family units in Canada reported one or more persons with expenditures for any type of medical care insurance, only four percent of family units in the under $1500 income group (31 percent of the population) reported such expenditure, while 9 percent of those in the $1500 to $3000 income group (43 percent of the population) and 14 percent of those in the over $3000 income group (26 percent of the population) reported purchase of medical care insurance.(1)

The ability of wage-earners to meet premium costs is linked with the problem of generally increasing price levels in the post-war period, including the costs of health services. Medical prices are guided by the minimum fee schedules of the provincial Colleges of Physicians and Surgeons, which vary from one province to another. If a

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(1) Dominion Bureau of Statistics and Department of National Health and Welfare, Canadian Sickness Survey 1950-51. Family Expenditures for Health Services by Income Groups, Special Compilation: No. 2, (Ottawa: D.B.S., 1953), Tables 4 and 5. Families reporting expenditures on medical insurance under "combined plans" have not been included. Income figures reported refer to income of heads of families, rather than total family income.

medical insurance plan is to succeed, its financial resources must make possible fair payments to those who provide services. Furthermore, it is apparent that the non-profit plans, in their attempts to make medical care insurance available to the whole population, must balance their objectives with respect to the range of benefits to be offered, with the necessity to establish a premium rate within the capacity of the average wage-earner. If it is assumed that the objective is a comprehensive range of benefits, the solvency of plans which are mainly financed by flat-rate contributions from the covered workers, can be maintained only if premiums are set at levels which tend to exclude the low-income group from membership. This problem has been recognized in the suggestions that have from time to time been made to assist marginal-income families in obtaining coverage by subsidizing their premiums.

The non-profit plans in the various provinces, recognizing the problem of premium costs to low-income families, have adopted several approaches to the provision of medical care insurance, which may involve provision of more than one type of contract with different benefits and premium rates, or encouragement of premium-sharing between the employers and the employees. Service plans in Manitoba, Ontario, Quebec and Nova Scotia have for sometime recognized the varying capacity of wage-earners to meet premiums, by offering members a choice between comprehensive and limited

contracts at different premium rates. In the three western provinces, comprehensive contracts were offered exclusively until 1953, but at the same time, compulsory employer premium-sharing was required by one of these plans. In the Atlantic provinces, a choice between limited surgical contracts with or without medical (non-surgical) benefits is available. Another approach is to distribute the premium costs for families with several members over the premiums to single persons and small families, although this method may be limited in its effectiveness.

Apart from the techniques described above for providing contracts priced at levels which potential purchasers can afford, employer-sharing is a further and complementary method of distributing premium costs. As already noted, such employer participation in the payment of premiums is compulsory in British Columbia, while most of the other plans actively encourage employers to share a portion of their employees' premium rates. That employer participation is sizeable is shown in preliminary tabulations from the Department of Labour's Survey of Working Conditions, April, 1953. These tabulations (which however also include contracts offered by private commercial insurance companies) indicate that about 80 percent of the 6476 manufacturing establishments reporting, had some type of prepaid sickness benefit plan for their workers, who accounted for 95 percent of all the workers employed by the reporting firms. Over 70

percent of the establishments with plans (with almost 80 percent of all workers in such establishments), paid a portion of the premiums on behalf of their covered workers. Fifty-five percent of the establishments with plans (with 57 percent of all workers in such establishments), paid 50 percent or more of the premium rate, including 7 percent which paid the premium in full. It should be noted however that this survey includes plans which provide cash sickness payments for wage loss due to illness (other than sick leave benefits), medical or hospital benefits, or a combination of several benefits. These preliminary data indicate that the division of the cost of premiums between employers and employees is an important development, and is perhaps one of the most encouraging methods of obtaining flexibility in financing voluntary medical care insurance in Canada.

APPENDICES

APPENDIX I

CHRONOLOGICAL LIST OF NON-PROFIT MEDICAL INSURANCE PLANS, BY YEAR IN WHICH OPERATIONS COMMENCED, AND PROVINCE OF INCORPORATION

Year	Plan	Province
1937	Associated Medical Services Inc. (AMS)	Ontario
1939	Windsor Medical Services Inc. (WMS)	Ontario
1939	Saskatoon Mutual Medical and Hospital Benefit Association (SMBA)	Saskatchewan
1939	Regina Mutual Medical Benefit Association[a] (RMBA)	Saskatchewan
1939	Medical Services Inc. Regina[a] (MSIR)	Saskatchewan
1940	Medical Services Association (MSA)	B. C.
1943	Melfort and District Mutual Medical Benefit Association[b] (MMBA)	Saskatchewan
1943	Woodstock Co-operative Medical Services Association (WOODSTOCK)	Ontario
1943	Credit Unions' Mutual Benefit Association (CUMBA)	Ontario
1944	Manitoba Medical Service (MMS)	Manitoba
1944	Fraser Valley Medical Dental Society (FVMDS)	B. C.
1946	Les Services de Santé du Québec (SSQ)	Quebec
1946	Co-operative Medical Services Federation (CMSF)	Ontario
1946	Credit Union and Co-operative Health Services Society (CU&C)	B. C.
1946	Medical Services Saskatoon Inc. (MSSI)	Saskatchewan
1946	Quebec Hospital Service Association[c] (QHSA)	Quebec
1948	Maritime Hospital Service Association[c] (MHSA)	Maritimes
1948	Physicians' Services Inc. (PSI)	Ontario
1948	Medical Services (Alberta) Inc. (MSI)	Alberta
1949	Group Medical Services (Regina)[a] (GMS)	Saskatchewan
1949	Maritime Medical Care Inc. (MMC)	N. S.
1952	Ontario Hospital Association Blue Cross Plan[c] (OHA)	Ontario

(a) Group Medical Services was created through an amalgamation of Regina MMBA and Medical Services Inc.

(b) This plan was absorbed by MSSI in 1951.

(c) These plans were incorporated earlier to offer hospital care benefits.

APPENDIX II

NUMBERS OF PERSONS ENROLLED IN NINE NON-PROFIT MEDICAL INSURANCE PLANS, BY TYPE OF CONTRACT, DECEMBER 31, 1937-1945

Province	Plan Contract	1937	1938	1939	1940	1941	1942	1943	1944	1945
Ont.	A.M.S. - "800"	733	4,020	12,762	22,267	28,612	30,811	31,691	32,433	33,356
	Group	-	-	-	-	-	-	-	-	265
"	W.M.S. - Group M.S.O.	-	-	-	1,684	3,506	4,911	6,760	6,537	7,656
	Non-Group M.S.O.	-	-	-	339	495	496	469	650	762
	S. and O.	-	-	-	-	-	-	-	-	605
	Total	-	-	-	2,043	4,001	5,407	7,229	7,187	9,023
Sask.	R.M.B.A.[a]	-	-	(b)	(b)	237	721	1,501	2,340	3,851
	S.M.B.A.	-	-	167	(b)	(b)	(b)	1,365	(b)	16,000
	M.S.I. (Regina)[a]	-	-	(b)	(b)	(b)	810	(b)	(b)	(b)
	M.M.B.A.[c]	-	-	-	-	-	-	(b)	(b)	4,000
B.C.	M.S.A.	-	-	-	-	601	2,581	6,588	10,871	19,242
	F.V.M.D.S.	-	-	-	-	-	-	-	(b)	(b)
Man.	M.M.S. - Group "A"	-	-	-	-	-	-	-	2,388	7,035
	Group "B"	-	-	-	-	-	-	-	5,915	18,080
	Total	-	-	-	-	-	-	-	8,303	25,115
	Total	733	4,020	13,100[e]	25,000[e]	35,000[e]	41,000[e]	50,000[e]	75,000[e]	112,000[e]

See p. 189 for notes.

NUMBERS OF PERSONS ENROLLED IN FOURTEEN NON-PROFIT MEDICAL INSURANCE PLANS, BY PLAN AND TYPE OF CONTRACT, AT 31 DECEMBER, 1946-1953

Province	Plan	Contract	1946	1947	1948	1949	1950	1951	1952	1953
B.C.	M.S.A.	-	59,051	97,709	126,279	140,454	164,494	190,815	204,770	228,685
Alta.	M.S.(A).I.	Group	-	-	1,621	15,189	22,591	30,733	47,647	58,827
		Non-Group	-	-	2,271	8,324	13,627	4,232	-	-
		Total	-	-	3,892	23,513	36,218	34,965	47,647	58,827
Sask.	M.S.S.I.	Individual	6,434	13,188	16,532	18,900	22,818	24,899	29,060	(b)
		Group "A"	1,863			6,032	6,205	2,996	2,994	(b)
		Group "B"	-	-	-	-	3,439	11,877	19,418	(b)
		Community	-	-	-	-	2,911	8,580	22,910	(b)
		Total	8,297	13,188	16,532	24,932	35,405	48,352	74,382	92,530
"	G.M.S.(a)		4,689	5,475	6,161	9,800	11,908	17,186	22,281	26,768
Man.	M.M.S.	Group "A"	8,502	8,965	8,526	8,653	10,342	7,192	10,356	11,214
		Group "B"	27,287	28,327	43,080	53,508	76,740	102,166	121,718	147,533
		Individ."Limited"	-	-	-	-	-	1,129	1,195	1,165
		" "Extended"	-	-	-	-	-	7,723	9,210	11,099
		Total	35,789	37,292	51,606	62,161	87,082	118,210	142,479	171,011
Ont.	P.S.I.	Blue - M.S.& O.	-	-	18,689	38,818	103,378	170,757	260,000(e)	313,321
		Green - S. & O.	-	-	2,574	3,670	6,463	7,479	12,000(e)	15,983
		Brown - In hospital	-	-	-	-	-	39,911	48,000(e)	61,680
		Total	-	-	21,263	42,488	109,768	218,147	320,068	390,984
"	W.M.S.	Group - M.S.& O.	15,609	46,083	65,268	67,543	85,396	94,791	121,215	139,003
		Non-Group-M.S.& O.	1,001	1,674	3,685	6,978	6,998	9,907		
		Group - S. & O.	2,158	2,509	1,192	1,273	1,185	877	1,168	1,195
		Non-Group- S.& O.)			296	323	314	284		
		Total	18,768	50,266	70,441	76,117	93,893	105,859	122,383	140,198

See p. 189 for notes.

Province	Plan	Contract	1946	1947	1948	1949	1950	1951	1952	1953
Ont.	O.H.A.	M.S. & O.	-	-	-	-	-	-	40,095	204,171
"	A.M.S.	Group	1,515	2,552	7,295	24,121	55,628	68,517	80,076	(b)
		"800"	37,444	41,328	41,751	26,136	-	-	-	-
		"1600"	-	-	-	14,292	29,493	26,105	24,818	(b)
		"900"	-	-	-	-	1,632	1,340	1,272	(b)
		Total	38,959	43,561	49,046	64,549	86,753	95,962	106,166	111,530
"	C.M.S.F.	S. & O.	-	676	1,531	2,992	6,965	15,359	35,926	43,201
Que.	S.S.Q.	"A" - Medical	435	4,055	7,060	9,840	13,169	15,542	22,818	37,433
		"B" - Surgical	1,210	6,970	11,385	16,315	21,427	24,648	31,218	48,981
		Total[d]	1,300	7,525	12,045	17,255	22,796	26,290	33,036	51,414
"	Q.H.S.A.	M.S. & O.	-	94,269	163,356	254,670	320,731	396,363	523,968	550,000[e]
		S. & O. only	-	67,603	91,585	104,648	148,385	147,041	77,302	75,000[e]
		Total	-	161,872	254,941	559,318	469,116	543,404	601,270	625,000[e]
Maritimes	M.H.S.A.	M. S. & O.	-	-	15,515	43,673	70,711	94,621	134,771[e]	140,000[e]
		S. & O. only	-	-	3,343	11,742	16,413	16,687	17,000[e]	17,000[e]
		Total	-	-	18,858	55,415	87,124	111,308	151,771	156,605
	M.M.C. (Nova Scotia)	M. S. & O.	-	-	-	10,000	29,550	44,325	51,000	52,129
		S. & O.	-	-	-	156	450	675	465	406
		Total	-	-	-	10,156	30,000	45,000	51,465	52,535
Canada	Total	13 Plans	166,853	417,564	632,595	889,150	1,241,522	1,570,857	1,953,739	2,353,459
ANNUAL RATE OF GROWTH %			50.5%	150.3	51.5	40.6	39.6	26.5	24.4	20.5

Notes: (a) In 1949, Regina Mutual Medical Benefit Association and Medical Services Incorporated (Regina) were amalgamated to form Group Medical Services. G.M.S. figures prior to 1949 relate to RMMBA.
(b) Figures not available.
(c) In 1951 this plan's 1000 members were absorbed into MSSI.
(d) Estimated unduplicated total of persons holding A, B and AB contracts.
(e) Estimates only, subject to revision.

APPENDIX III

SCOPE OF MEDICAL BENEFITS OFFERED BY NON-PROFIT MEDICAL INSURANCE PLANS IN EACH PROVINCE, BY TYPE OF BENEFIT, AND BY CONTRACT, DECEMBER 1951.

Benefit \ Province	B.C.	ALTA.	SASKATCHEWAN					MANITOBA			
Plan	Medical Service Assn.	Medical Services Inc.	Medical Services (Saskatoon) Inc.				Group Medical Services	Manitoba Medical[a] Service			
Type of Contract			Individual	A	B	Community		Group A	Group B	Non-Groups Limited	Non-Groups Extended
General Medical (Non-Surgical) Services	X	X	W.P. 1 mo.	X	X	X	W.P. 1 mo.	only in hosp.	X	only in hosp.	X
Physicians' Calls - Home	X	X	X	X	X	X	X	-	X	-	X
- Office	X	X	X	X	X	X	X	-	X	-	Max. of 12 calls per person per yr.
- Hospital	X	X	X	X	X	X	X	31 da. per person per yr.	X	31 da. per person per yr.	X
Consultations	X	First visit only paid at Specialist rates					X	in hosp. only	X	1 med. and 1 surg. per person per yr.	
X-Ray - Diagnostic	X	X	$25. max. per person per yr. for all diagnostic aids				75 per cent of cost	For suspected fracture only	X	For surg. or fract. up to max. $35. per year	$35. max. per yr. per contr. for Lab. & X-Ray
- Fractures	X	X	unlimited					X	X		
Therapeutic	X	X	X	X	X	X	No Deep X-Ray	-	X	-	X
Diagnostic Procedures	X	X	$25. max. per person per yr. for all diagnostic aids				X	-	X	-	X
Laboratory Procedures	X	X					$10.max. per yr.	-	X	-	$35.max. for X-Ray and Lab.
Surgical Operations (Home, Office, and Hospital)	X	X	W.P. 3 mos.	X	X	X	W.P. 2 mos.	X	X	X	X
- Herniotomies	X	X	X	X	X	X	W.P. 12 mos.	W.P. is 12 mos.			
- Hysterectomies	X	X	W.P. 24 mos.	W.P. 12 mos.	X	X	W.P. 24 mos.	W.P. 12 mos.		W.P. 18 mos.	
- Tonsils & Adenoids	X	X	W.P. 12 mos.		X	X	W.P. 12 mos.	W.P. is 12 mos.			
- Caesarean Sections	W.P 9 mos.	W.P. 9 mos.	W.P. 9 mos.		X	X	W.P. 10 mos.	W.P. 10 mos.		W.P. 12 mos.	
- D & C	X	W.P. 9 mos.	W.P. 9 mos.		X	X	W.P. 10 mos.	W.P. 10 mos.		W.P. 12 mos.	
- Other Female Surgery	X	X	W.P. 24 mos.	W.P. 12 mos.	X	X	W.P. 24 mos.	W.P. 12 mos.		W.P. 18 mos.	
- Prostatism	X	X	W.P. 24 mos.	W.P. 12 mos.	X	X	W.P. 24 mos.	W.P. 12 mos.		W.P. 18 mos.	
Anaesthetist	X	X	X	X	X	X	X	$10. max. if not hosp. supplied	X	$10. max. if not hosp. supplied	If not supplied by hosp.
Confinements (Home, Office and Hospital)	W.P. 9 mos.	W.P. 9 mos.	W.P. 9 mos.	W.P. 9 mos.	X	X	W.P. 10 mos.	Incl. 6 pre- & 1 post-nat. visits W.P. 10 mos.		W.P. 12 mos.	
Eye Refractions	-	-	Not unless needed for diagnosis or treatment of disease				-	-	W.P. 12 mos.	-	X
Fractures	X	X	X	X	X	X	X	X	X	X	X
Pre-Existing Conditions	Z	X	-	-	X	X	-	W.P. 12 mos.		-	-
Other Conditions Excluded	Usual	Usual	Usual	Usual	Usual	Usual	Usual	Usual			
Total Expenditure Limit per illness or per year			$500.	$500.	$500.	$500.					

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APPENDIX III (Cont'd)

Province	ONTARIO									
Benefit / Plan	Physicians' Services Inc.			Associated Medical Services			Windsor[b] Medical Services		Cooperative Medical Services Federation[c]	Ontario Hospital Association Blue Cross Plan[d]
Type of Contract	Blue	Green	Brown	1600	900	G.M.S.	M.S. & O. Group	S. & O. Group	S. & O.	M.S. & O.
General Medical (Non-Surgical) Services	X	-	only in hosp.	only in hospital			X	-	-	only in hospital
Physicians' Calls - Home	X	-	-	-	-	-	X	-	-	-
- Office	X	-	-	-	-	-	X	-	-	-
- Hospital	X	-	51 da. per yr.	X	X	X	X	-	-	$3 per day for 51 days per yr.
Consultations	X	X	1 per admission	in hospital only Spec. $10; G.P. $5.			X	-	-	1 per admission
X-Ray - Diagnostic	$35. maximum	$35. per person	$35. per yr.	in hospital only			X	$35.max.per person per yr.	For sug. or frac. up to max. $15. or $25. per person per yr.	In-patients Covered under Accomp-anying Hospital Contract
- Fractures	unlimited			X	X	X	unlimited			
Therapeutic	A	-	$150.max. per yr.	X	X	X	X	-	-	
Diagnostic Procedures	X	For surgery & Obstet. only	X				X	For surgery only	-	
Laboratory Procedures	Excl. Hosp. Proc.	"	-	in hospital only			X	"	-	
Surgical Operations (Home, Office, and Hospital)	X	X	only in hosp.	X	X	X	X	X	Patient pays first $15.	$300 max. only in hospital
- Herniotomies	W.P. 6 mos		X	X	X	X	X	W.P.10 mos.	W.P. 10 or 12 mos.	X
- Hysterectomies	X	X	X	X	X	X	X	X	X	X
- Tonsils & Adenoids	W.P. 6 mos.		X	W.P. 12 mos.		X	X	W.P.10 mos.	W.P. 10 or 12 mos.	X
- Caesarean Sections	W.P. 10 mos.			Max. $100		Max.$85.	W.P. 10 mos.		W.P. 12 mos.	W.P. 10 mos.
- D & C	W.P. 10 mos.			W.P. 10 mos.		W.P. 10 mos.	W.P. 10 mos.		W.P. 12 mos.	X
- Other Female Surgery	X	X	X	W.P. 24 mos.		X	X	W.P. 10 mos.	W.P. 10 or 12 mos.	X
- Prostatism	X	X	X	W.P. 24 mos.		X	X		X	X
Anaesthetist	X	X	X	$5. per ½ hr.			X	X	$15. max.	X
Confinements (Home, Office and Hospital)	W.P. 10 mos.			W.P. 10 mos. Max.$60.		Max.$50.	W.P. is 10 mos.		W.P. 12 mos.	W.P. 10 mos. $60 max. only in hospital
Eye Refractions	1 per yr. W.P 10 mos.	-	-	-	-	-	1 per yr. W.P. 12 mos.	-	-	-
Fractures	X	X	X	X	X	X	X	X	X	X
Pre-Existing Conditions	X	X	X	-	-	Employee only covered	W.P. 6 mos.	X	X	X
Other Conditions Excluded	Institutionalized cases excluded			Usual			Usual		Usual	Treatment provided under Statute
Total Expenditure Limit per illness or per year				$1600.[e] per yr.	$900. per yr.	$800. per yr.			$500. per illness	

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APPENDIX III (Cont'd)

Benefit \ Province	QUEBEC				N.S.		MARITIMES	
Plan	Services de Santé du Québec[b]		Quebec Hosp. Service Association		Maritime Medical Care		Maritime Hospital Service Association	
Type of Contract	A	B	M.S. & O.	S. & O.	M.S. & O.	S. & O.	M.S. & O.	S. & O.
General Medical (Non-Surgical) Services	X	only in hosp.	only in hosp.	-	X	-	only in hosp.	-
Physicians' Calls - Home	X	-	-	-	X	-	-	-
- Office	X	-	-	-	X	-	-	-
- Hospital	X	Max. of 42 days per admission	$3. per da. for 31 da. per admission	-	X	-	$3. per da. from 3rd to 31st da. per admission	
Consultations	50% of rate	$5. in hosp. only	-	-	X	-	-	-
X-Ray - Diagnostic	50% of rates max.of $50.per yr.only on reference	-	In-patients Covered under Accomp- anying Hospital Contract		$25. per person per year	Max.of $25.per year.	In-patients Covered under Accomp- anying Hospital Contract	
- Fractures		-			unlimited			
Therapeutic		-			X	-		
Diagnostic Procedures	X	-			X	Only for surg. or obstet.		
Laboratory Procedures	50% max. $50.	-			X	"		
Surgical Operations (Home, Office and Hospital)	only minor	$200 max.	$200 max.		X	X	$150. maximum	
- Herniotomies	-	W.P. 6 mos.	W.P. 6 mos.		W.P. 6 mos.		W.P. 6 mos.	
- Hysterectomies	-	X	X	X	X	X	X	X
- Tonsils & Adenoids	W.P. 6 mos.		W.P. 6 mos.		W.P. 6 mos.		W.P. 6 mos.	
- Caesarean Sections	-	W.P. 9 mos.	W.P. 9 mos.		W.P. 10 mos.		W.P. 9 mos.	
- D & C	W.P. 9 mos.	W.P. 9 mos.	X	X	W.P. 10 mos.		X	X
- Other Female Surgery	-	X	X	X	W.P. 6 mos.		X	X
- Prostatism	-	X	X	X	X	X	X	X
Anaesthetist	-	-	-	-	X	X	X	X
Confinements (Home, Office and Hospital)	W.P. 9 mos.		W.P. 9 mos. $50 max.		W.P. 10 mos.		W.P. 9 mos. $50. max.	
Eye Refractions	-	-	-	-	1 per yr. W.P. 10 mos.	-	-	-
Fractures	X	X	X	X	X	X	X	X
Pre-Existing Conditions	W.P. 10 mos.		W.P. 11 mos.		X	X	-	-
Other Conditions Excluded	Usual		Usual		Usual		Usual	
Total Expenditure Limit per illness or per year								

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APPENDIX III (Concluded)

Notes:

(a) No extra-billing by specialist or general practitioner permitted.
(b) No extra-billing by specialist or general practitioner permitted for members under certain income limits.
(c) These data represent the average benefits offered by the various cooperative associations in the Federation.
(d) This plan was not introduced until August, 1952.
(e) This maximum figure includes expenditure for hospital benefits.

Code:

M.S. & O.: Medical, Surgical and Obstetrical Care Plan.
S. & O. : Surgical and Obstetrical Care Plan.

X - Benefit provided.
- - Benefit not provided.
Z - Treated unless member has received two treatments during the two weeks prior to enrollment.
W.P. - Waiting period given in months.
Usual - Includes services for T.B., mental, V.D., contagious diseases, alcoholism, drug addiction and epilepsy.

APPENDIX IV

STATEMENTS OF TOTAL AND PER CAPITA REVENUES, EXPENDITURES, AND NET OPERATING SURPLUSES, BY SOURCE OF REVENUE AND TYPE OF EXPENDITURE, NON-PROFIT MEDICAL INSURANCE PLANS, FISCAL YEAR 1949

Plan	Revenue			Expenditure				Net Operating Surpluses[b]
	Contributions		Total[a]	Benefits		Administration	Total	
	Medical	Hospital		Medical	Hospital			
	$	$	$	$	$	$	$	$
MSA Total	2,552,114	-	2,555,931	2,178,184	-	161,440	2,339,624	216,307
Per Capita	19.64	-	19.67	16.76	-	1.24	18.01	1.66
MSI Total	211,991	-	211,991	187,646	-	30,400	218,046	-6,055
Per Capita	12.14	-	12.14	10.74	-	1.74	12.48	-.34
MSSI Total	308,854	-	312,170	235,462	-	49,085	284,547	27,623
Per Capita	15.14	-	15.30	11.54	-	2.41	13.95	1.35
GMS Total	-	-	-	-	-	-	-	-
Per Capita	-	-	-	-	-	-	-	-
MMS Total	766,017	-	770,959	677,874	-	79,348	757,222	13,737
Per Capita	13.50	-	13.59	11.95	-	1.40	13.35	.24
PSI Total	532,791	-	534,637	385,610	-	74,947	460,557	74,080
Per Capita	16.19	-	16.25	11.72	-	2.28	14.00	2.25
WMS Total	1,346,255	-	1,348,081	1,173,043	-	98,103	1,271,146	76,935
Per Capita	17.98	-	18.00	15.66	-	1.31	16.97	1.03
MMC Total								
Per Capita			NOT AVAILABLE					
SSQ Total	137,072	100,931	242,304	92,432	109,381	52,690	254,503	-12,199
Per Capita	8.96	7.05	15.84	6.04	7.64	3.44	16.63	-.79
CMSF Total	26,350	344,245	374,327	13,997	255,599	53,817	323,413	50,914
Per Capita	9.25	10.30	11.20	4.91	7.65	1.61	9.68	1.52
MHSA Total	439,337	2,189,395	2,646,441	262,595	2,007,314	288,586	2,558,496	87,945
Per Capita	10.93	7.47	9.03	6.54	6.85	.98	8.73	.30
QHSA Total	6,516,612		6,550,191	1,998,766[c]	3,476,934[c]	627,845	6,103,545	446,646
Per Capita	14.17		14.24	6.51	7.56	1.37	13.27	.97
AMS Total	1,050,295		1,066,111	614,032	184,648	231,051	1,029,731	36,381
Per Capita	18.01		18.28	10.53	3.65	3.96	17.66	.62
11 Plans Total	9,506,981	7,015,278	16,613,143	7,819,641	6,033,876	1,747,312	15,600,830	1,012,314
Per Capita	12.57	8.24	13.93	10.34	7.09	1.47	13.08	.85

See page 200 for notes.

APPENDIX IV (Cont.)
1950

Plan	Revenue: Contributions: Medical	Revenue: Contributions: Hospital	Revenue: Total[a]	Expenditure: Benefits: Medical	Expenditure: Benefits: Hospital	Expenditure: Administration	Expenditure: Total	Net Operating Surpluses[b]
	$	$	$	$	$	$	$	$
MSA Total	3,003,533	-	3,015,160	2,454,609	-	196,404	2,651,013	364,147
Per Capita	20.74	-	20.82	16.95	-	1.36	18.31	2.51
MSI Total	467,557	-	468,098	457,452	-	60,353	517,805	-49,707
Per Capita	14.56	-	14.57	14.24	-	1.88	16.12	-1.55
MSSI Total	451,631	-	455,296	377,990	-	61,083	439,072	16,224
Per Capita	15.04	-	15.16	12.59	-	2.03	14.62	.54
GMS Total	145,250	-	146,010	124,418	-	13,562	137,980	8,030
Per Capita	14.01	-	14.08	12.00	-	1.31	13.31	.77
MMS Total	1,034,290	-	1,038,430	917,166	-	119,406	1,036,572	1,858
Per Capita	13.86	-	13.92	12.29	-	1.60	13.89	.03
PSI Total	1,098,324	-	1,104,771	836,594	-	127,452	964,046	140,725
Per Capita	16.22	-	16.32	12.36	-	1.88	14.24	2.08
WMS Total	1,545,608	-	1,550,458	1,237,026	-	112,120	1,349,146	201,312
Per Capita	18.61	-	18.66	14.89	-	1.35	16.24	2.42
MMC Total	335,368	-	335,368	314,667	-	40,001[c]	354,668[c]	-19,300[c]
Per Capita	15.24	-	15.24	14.30	-	1.82	16.12	-.88
SSQ Total	192,685	172,075	367,905	152,185	168,933	64,232	385,350	-17,445
Per Capita	9.18	8.88	17.52	7.25	8.72	3.06	18.35	-.83
CMSF Total	61,295	607,475	680,593	49,612	503,527	88,119	641,258	39,034
Per Capita	9.58	7.37	8.25	7.75	6.11	1.07	7.78	.47
MHSA Total	749,040	2,335,637	3,105,506	532,091	2,337,138	366,773	3,236,002	-130,496
Per Capita	10.90	7.90	10.51	7.75	7.91	1.24	10.95	-.44
QHSA Total	8,160,981		8,216,684	2,501,549[c]	4,392,146[c]	746,905	7,861,258	355,426
Per Capita	11.51		14.61	6.04	7.81	1.33	13.98	.63
AMS Total	1,103,454		1,116,236	585,612	290,419	267,296	1,143,327	-27,091[d]
Per Capita	15.42		15.60	8.19	5.35	3.73	15.98	-.38
13 Plans Total	12,783,636	8,680,567	21,600,515	10,540,971	7,692,163	2,263,705	20,717,497	882,717
Per Capita	12.21	8.49	14.43	10.07	7.53	1.51	13.84	.59

See page 200 for notes.

APPENDIX IV (Cont.)
1951

Plan	Revenue			Expenditure				Net Operating Surpluses[b]
	Contributions		Total[a]	Benefits		Administration	Total	
	Medical	Hospital		Medical	Hospital			
	$	$	$	$	$	$	$	$
MSA Total	3,513,098	-	3,532,701	3,252,438	-	235,383	3,487,821	44,880
Per Capita	20.91	-	21.03	19.36	-	1.40	20.76	.27
MSI Total	617,284	-	620,802	508,352	-	84,714	593,066	27,736
Per Capita	16.17	-	16.27	13.32	-	2.22	15.54	.73
MSSI Total	688,622	-	694,513	570,844	-	93,228	664,072	30,441
Per Capita	16.36	-	16.50	13.56	-	2.21	15.77	.72
GMS Total	206,578	-	208,402	186,036	-	15,689	201,725	6,677
Per Capita	15.30	-	15.44	13.78	-	1.16	14.94	.50
MMS Total	1,859,828	-	1,866,668	1,551,951	-	186,631	1,738,583	128,085
Per Capita	18.12	-	18.19	15.12	-	1.82	16.94	1.25
PSI Total	2,966,723	-	2,979,598	2,450,330	-	272,272	2,722,602	256,996
Per Capita	16.70	-	16.77	13.79	-	1.53	15.32	1.45
WMS Total	1,931,564	-	1,940,898	1,657,382	-	137,042	1,794,424	146,474
Per Capita	18.93	-	19.02	16.24	-	1.34	17.58	1.44
MMC Total	597,333	-	597,333	550,535	-	64,555	615,090	-17,758
Per Capita	15.93	-	15.93	14.68	-	1.72	16.40	-.47
SSQ Total	242,713	207,197	453,330	196,980	192,394	61,943	451,317	2,013
Per Capita	9.33	8.75	17.44	7.58	8.13	2.38	17.36	.08
CMSF Total	117,403	879,712	1,013,968	86,549	805,307	122,398	1,014,254	-286
Per Capita	9.16	7.05	8.13	6.75	6.46	.98	8.13	-.002
MIISA Total	970,702	2,954,643	3,948,875	843,806	2,701,559	460,915	4,006,280	-57,405
Per Capita	9.80	9.80	13.09	8.52	8.96	1.53	13.28	-.19
QHSA Total	9,240,199		9,310,357	3,170,102[c]	4,943,580[c]	881,367	9,227,049	83,308
Per Capita	15.01		15.13	6.26	8.03	1.43	14.99	.14
AMS Total	1,263,237		1,275,442	570,114	377,484	269,292	1,216,890	58,552
Per Capita	13.87		14.01	6.26	6.48	2.96	13.37	.64
13 Plans Total	18,082,107	10,174,729	28,442,887	15,595,419	9,020,324	2,885,429	27,733,173	709,713
Per Capita	12.76	9.12	15.45	11.01	8.09	1.57	15.07	.38

See page 200 for notes.

APPENDIX IV (Cont.)
1952

Plan	Revenue			Expenditure				Net operating Surplus
	Contributions		Total	Benefits		Administration	Total	
	Medical	Cash			Cash			
MSA Total	$ 4,561,346	$ -	$ 4,577,205	$ 4,218,221	$ -	$ 264,801	$ 4,483,022	$ 94,183
Per Capita	24.13	-	24.22	22.32	-	1.40	23.72	.50
MSI Total	656,961	-	667,630	531,720	-	108,448	640,168	27,462
Per Capita	15.90	-	16.16	12.87	-	2.63	15.50	.66
MSSI Total	1,081,287	-	1,096,166	921,229	-	112,795	1,034,024	62,142
Per Capita	17.09	-	17.32	14.56	-	1.78	16.34	.98
GMS Total	290,497	-	292,491	287,829	-	26,287	314,116	-21,625
Per Capita	15.29	-	15.39	15.15	-	1.38	16.53	-1.14
MMS Total	2,648,950	-	2,662,560	2,338,500	-	242,508	2,581,008	81,552
Per Capita	20.64	-	20.75	18.22	-	1.89	20.11	.64
PSI Total	4,596,992	-	4,621,459	3,850,380	-	415,963	4,266,343	355,116
Per Capita	17.08	-	17.17	14.31	-	1.55	15.85	1.32
WMS Total	2,156,628	-	2,172,382	1,973,284	-	165,466	2,144,750	27,632
Per Capita	18.94	-	19.08	17.36	-	1.45	18.84	.24
MMC Total	826,250	-	828,023	702,474	-	80,997	783,471	44,552
Per Capita	17.14	-	17.18	14.57	-	1.68	16.25	.93
SSC Total	307,286	254,093	566,027	247,755	239,399	68,956	559,110	6,917
Per Capita	10.46	9.05	19.27	8.43	8.52	2.35	19.03	.24
CMSF Total	232,223	1,166,192	1,433,980	184,901	1,014,258	161,495	1,360,654	73,326
Per Capita	9.06	7.96	9.79	7.21	6.92	1.10	9.29	.50
MHSA Total	1,343,711	3,403,311	4,774,354	1,111,352	3,165,684	508,127	4,785,163	-11,099
Per Capita	10.20	13.58						-.04
QHSA Total	11,118,954		11,135,352	3,645,953[c]	6,243,398[c]	1,054,515	11,302,865	-107,513
Per Capita	17.44		17.55	6.37	9.79	1.65	17.72	-.17
AMS Total	1,453,497		1,467,439	676,437	425,747	254,769	1,356,953	110,486
Per Capita	14.68		14.82	6.83	7.60	2.57	13.71	1.12
CHA Total	40,746	22,088,729	22,361,300	37,714	18,807,448	1,598,825	20,443,987	1,917,373
Per Capita	2.04	13.57	13.74	1.89	11.55	.98	12.56	1.18
14 Plans Total	23,734,200	34,493,453	58,716,138	20,733,749	24,895,934	5,063,952	56,055,634	2,660,504
Per Capita	13.56	12.36	15.84	11.85	10.72	1.36	15.12	.72

See page .00 for notes.

APPENDIX IV (Continued)
1953

Plan	Contributions		Benefits	
	Medical	Hospital	Medical	Hospital
	$	$	$	$
MSA Total	5,591,118	-	4,891,191	-
Per Capita	27.09	-	23.70	-
MSI Total	977,083	-	770,551	-
Per Capita	18.37	-	14.48	-
MSSI Total	1,520,097	-	1,268,539	-
Per Capita	18.00	-	15.36	-
GMS Total	408,726	-	337,413	-
Per Capita	17.17	-	14.18	-
MMS Total	3,223,268	-	3,092,464	-
Per Capita	20.68	-	19.83	-
PSI Total	6,760,713	-	5,657,286	-
Per Capita	18.51	-	15.49	-
WMS Total	2,497,197	-	2,330,280	-
Per Capita	18.83	-	17.57	-
MMC Total	851,545	-	736,992	-
Per Capita	16.36	-	14.16	-
SSQ Total	507,010	418,875	405,631	396,360
Per Capita	11.16	9.56	8.93	9.05
CMSF Total	325,647	1,233,164	260,517	1,060,466
Per Capita	8.23	7.47	6.59	6.43
MHSA Total	1,534,163	3,600,000[c]	1,183,663	3,300,000[c]
Per Capita	10.00[c]	12.40[c]	7.70[c]	11.40[c]
QHSA Total	5,000,000[c]	8,000,000[c]	4,200,000[c]	7,200,000[c]
Per Capita	8.15[c]	12.40[c]	6.85[c]	11.15[c]
AMS Total	1,512,580		706,823	415,125
Per Capita	14.65		6.85	7.68
OHA Total	25,579,053		23,766,256	
Per Capita	14.66		13.62	
14 Plans Total	31,550,000[c]	38,000,000[c]	27,140,000[c]	34,870,000[c]
Per Capita	14.60[c]	12.90[c]	12.55[c]	11.85[c]

See page 200 for notes.

Notes:

The amounts used in this appendix as total benefit expenditures represent actual payments to physicians, and not the full amount of allowed claims for medical services received by the members. Operating surpluses are made possible by pro-rating payments to the physicians.

(a) Including interest on investments, but not receipts for administering provincial or municipal schemes as in the cases of GMS and MMC
(b) Before any money had been allocated to reserves.
(c) Estimates only; subject to revision.
(d) A surplus of $88,180 would have been realized if the "800 Plan", which terminated early in 1950, were excluded.

Per capita figures in this appendix are based on the following average annual enrollments:

Plan	1949		1950		1951		1952		1953	
	Medical	Hospital	Medical	Hospital	Medical	Hospital	Medical	Hospital	Medical	Hospital
MSA	129,932	-	144,800	-	168,000	-	189,000[c]	-	206,400[c]	-
MSI	17,467	-	32,123	-	38,166	-	41,300[c]	-	53,200[c]	-
MSSI	20,400	-	30,030	-	42,098	-	63,270	-	83,500[c]	-
GMS	-	-	10,370	-	13,500	-	19,000[c]	-	23,800[c]	-
MMS	56,749	-	74,622	-	102,646	-	128,345	-	155,897	-
PSI	32,910	-	67,700	-	177,679	-	269,100[c]	-	365,263	-
WMS	74,888	-	83,065	-	102,064	-	113,864	-	132,597	-
MMC	-	-	22,000[c]	-	37,500[c]	-	48,200[c]	-	52,036	-
SSQ	15,300	14,310	21,000	19,379	26,000	23,677	29,376	28,087	45,423	43,818
CMSF	2,850	22,417	6,400	82,465	12,818	124,697	25,642	146,513	39,562	164,978
MHSA	40,181	292,997	68,692	295,376	99,003	301,587	131,540	293,900[c]	153,400	290,000[c]
QHSA	307,129	459,860	414,217	562,257	506,260	615,557	572,337[c]	637,700[c]	613,000[c]	645,000[c]
AMS	58,321	50,532	71,539	54,277	91,064	58,244	99,000[c]	56,000[c]	103,228	54,026
OHA	-	-	-	-	-	-	20,000[c] (4 mos.)	1,628,000[c]	132,176	1,744,897
Total	756,127	851,116	1,046,558	1,022,079	1,416,798	1,115,497	1,749,974	2,790,200[c]	2,159,482[c]	2,942,719[c]

APPENDIX V

AMOUNT OF AND PERCENTAGE INCREASE IN MONTHLY PREMIUM RATES UNDER FOURTEEN NON-PROFIT MEDICAL INSURANCE PLANS, BY TYPE OF CONTRACT AND FAMILY SIZE, 1948 AND 1952

Plan	Single			Married			Family		
	1948	1952	Per Cent Increase	1948	1952	Per Cent Increase	1948	1952	Per Cent Increase
	$	$	$	$	$	$	$	$	$
Service Plans									
Comprehensive									
M.S.A.(a)	1.44	2.60	80.6	4.38	7.80	78.1	4.38	7.80	78.1
M.S.I.(b)	1.60	2.00	25.0	3.20	4.25	32.8	4.00(c)	6.00	50.0
M.S.S.I. A - Group	1.40	1.75	25.0	2.80	3.50	25.0	3.80(d)	5.00	31.6
B - Group	-	1.75	-	-	3.50	-	-	5.00	-
Community	-	1.66	-	-	3.33	-	-	5.00	-
Individual	1.50	2.00	33.3	3.00	4.00	33.3	4.00(e)	5.25	31.3
G.M.S.(f)	1.50(g)	2.00	33.3	3.00(g)	4.00	33.3	3.50(g)	5.25	50.0
M.M.S. B	2.00	2.50	25.0	4.00	5.00	25.0	4.00	6.00	50.0
Ext. (Ind.)	-	3.50	-	-	7.00	-	-	7.00	-
P.S.I. Blue	1.50	1.85	23.3	3.50	4.25	21.4	5.00	6.25	25.0
W.M.S. M.S.O.	1.40	1.85	32.1	2.65	3.70	39.6	3.60(h)	5.00(i)	38.9
M.M.C. M.S. & O.	1.50(g)	2.20	46.7	3.50(g)	4.20	20.0	4.75(j)	5.20(k)	9.5
A.M.S. 800 (Ind.)(l)	2.00	-	-	3.75	-	-	5.25(m)	-	-
Limited									
M.M.S. A (M.S. & O.)	.60	1.25	108.3	1.75	2.50	42.9	1.75	3.00	71.4
Ltd. (Ind.)	-	1.75	-	-	3.50	-	-	3.50	-
P.S.I. Green (S. & O.)	.75	.75	0	1.75	1.75	0	2.50	2.50	0
Brown (M.S. & O.)	-	1.00	-	-	2.25	-	-	3.10	-
W.M.S. S. & O.	.90	.90	0	2.25	2.25	0	2.25	2.25	0
	1.35	1.35(n)	0						
S.S.Q. A (Med.)	1.15	1.15	0	2.00	2.00	0	2.00	2.00	0
B (M.S. & O.)	.75	.75	0	2.00	2.00	0	2.00	2.00	0
M.M.C. S. & O.	.75	.75	0	1.75	1.75	0	2.50	2.50	0
Indemnification Plans									
A.M.S. 1600(o)(Ind.)	2.00(g)	2.00	0	3.75(g)	3.75	0	5.25(g)	5.25(m)	0
900 (Ind.)	-	1.30	-	-	2.60	-	-	3.60(p)	-
G.M.S. (Excl. hosp.)	.70	.70	0	1.65	1.65	0	2.40	2.40	0
C.M.S.F. S. & O.(q)	1.04-1.25	1.04-1.25	0	2.08-2.50	2.08-2.50	0	2.08-2.50	2.08-2.50	0
Ontario Blue Cross	-	.95	-	-	2.95	-	-	2.95	-
Q.H.S.A. M.S. & O.	1.00	1.00	0	2.75	2.75	0	2.75	2.75	0
S. & O.	.60	.60	0	1.75	1.75	0	1.75	1.75	0
M.H.S.A. M.S. & O.	1.05	1.10	4.8	2.90	3.00	3.4	2.90	3.00	3.4
S. & O.	.65	.70	7.7	1.90	2.00	5.3	1.90	2.00	5.3

See page 202 for notes.

Notes:

(a) These rates vary between groups, depending on sickness experience and the proportion of female members.
(b) Persons over 65 years pay an additional 40 cents, and adult dependents pay $2.00.
(c) Families of 4 or more paid $4.50.
(d) Families of 4 paid $4.60, of 5 paid $5.20, of 6 paid $5.60, of 7 paid $6.00, of 8 paid $6.40, and of 9 or more paid $6.50.
(e) Families of 4 paid $4.75, of 5 paid $5.50, of 6 paid $6.00, of 7 paid $6.50, and of 8 or more paid $7.00.
(f) Persons leaving group enrollment pay an additional 25 cents.
(g) Rate applies to 1949 when plan was inaugurated.
(h) Families of 4 paid $4.35, of 5 or more paid $5.00.
(i) Families of 4 pay $6.10, of 5 or more pay $7.00. Adult dependents pay $1.85.
(j) Families of 4 or more paid $5.50.
(k) Families of 4 or more pay $6.20.
(l) Plan included hospital care benefits up to $3.50 per day plus $15.00 for extras.
(m) Families of 4 pay $6.50, of 5 or more pay an additional $1.00 for each extra dependent.
(n) Males pay 90 cents, females $1.35.
(o) Plan includes hospital care benefits up to $9.00 per day.
(p) Families of 4 or more pay an additional 75 cents for each extra dependent.
(q) Rates shown are ranges for several co-operative plans.

Key to Abbreviations:

Ext. - Extended Medical Benefits
Ind. - Individual Contract
Ltd. - Limited Medical Benefits
M.S. & O. - Medical, Surgical and Obstetrical Care
S. & O. - Surgical and Obstetrical Care only
Med. - Medical care only

APPENDIX VI

AVERAGE EXPENDITURE PER PARTICIPANT MONTH, AND PERCENTAGE DISTRIBUTION OF EXPENDITURES ON MEDICAL CARE BENEFITS, BY ITEM OF SERVICE, NINE NON-PROFIT COMPREHENSIVE[a] MEDICAL INSURANCE PLANS, SELECTED YEARS 1947-1951.

Item of Service	PLAN A			PLAN B			PLAN C			PLAN D			PLAN E		PLAN F			PLAN G		PLAN H			PLAN J	Average 8 plans
	1949	1950	1951	1949	1950	1951	1949	1950	1951	1949	1950	1951	1950	1951	1947	1948	1949	1950	1951	1948	1950	1951	1951	1951
	EXPENDITURE PER CAPITA ($)																							
Physicians' Calls:																								
Office	.444 / .217	.467 / .246	.580 / .321	.559 / .391	.576	.655 / .463	.551 / .343	.492 / .302	.586 / .353	.363 / .200	.411 / .228	.463 / .250	.614 / .328	.636 / .321	.50 / .22	.55 / .26	.58 / .25	.484 / .300	.475 / .288	.35	.39 / .27	.49 / .32	.609 / .387	.593[e] / .367
Home	.152	.138	.166	.098		.112	.124	.113	.150	.077	.080	.068	.217	.240	.17	.19	.22	.067	.068		.05	.07	.148	.136
Night and Holiday	.009	.017	.017				.018	.013	.015			.018						.018	.024					.017
Hospital[b]	.037	.041	.046	.070		.080	.047	.046	.049	.086	.103	.117	.055	.058	.03	.04	.04	.090	.081		.07	.10	.059	.066
Consultations	.029	.025	.030	-		-	.018	.019	.019			.010	.014	.017	.08	.06	.07	.010	.015				.015	.021
X-Ray Service:																								
Diagnostic	.063 / .055	.062 / .058	.076 / .070			.144	.076	.081	.087 / .072	.071	.069	.067 / .063	.074	.063	.08	.10	.10	.081 / .076	.090 / .084	.08	.09	.10	.142 / .136	.107[e] / .089
Therapeutic	.008	.004	.005	.279	.192				.014			.004						.005	.006				.006	.008
Laboratory & Other Diagnostic Procedures	.006[c]	.006[c]	.005[c]			.080	.017	.018	.023	.045	.042	.035	.020	.014	-	-	.05	.033	.035	.03	.05	.05	.050	.050
Surgical Operations	.294	.313	.372			.527	.413	.384	.387	.307	.328	.347	.293	.259	.28	.34	.32	.385	.327	.35	.32	.35	.370	.409
Surgical Assistants							.004	.001	.001	.009	.013	.015						.018	.014				.003	
Anaesthetists	.050	.050	.062				.080	.075	.073	.039	.044	.048	.042	.040	.07	.07	.07	.058	.050	.04	.04	.04	.001	.066
Confinements	.025	.040	.053	.559	.645	.080	.086	.107	.114	.102	.115	.132	.016	.046	.16	.14	.11	.090	.094	.10	.08	.09	.047	.086
Refractions	.009	.014	.014	-	-	.112 -	.021	.022	.021	-	-	-	-	-	.02	.02	.02	-	-	-	-	-	.030	.020
Other[d]	.050	.070	.058	-	-	-	.075	.073	.074	.025	.028	.023	.074	.104	-	-	-	.030	.025	.02	.03	.03	.037	.054
TOTAL	.941	1.022	1.220	1.396	1.413	1.597	1.320	1.254	1.364	.961	1.050	1.130	1.132	1.162	1.11	1.22	1.25	1.179	1.110	.97	1.00	1.15	1.291	1.336[e]

Notes on p.204

Item of Service	PLAN A			PLAN B			PLAN C			PLAN D			PLAN E		PLAN F			PLAN G		PLAN H			PLAN J	Average 8 Plans
	1949	1950	1951	1949	1950	1951	1949	1950	1951	1949	1950	1951	1950	1951	1947	1948	1949	1950	1951	1948	1950	1951	1951	1951
	PER CENTAGE DISTRIBUTION																							
Physicians' Calls: Office	47.2 / 23.1	45.7 / 24.1	47.6 / 26.3	40. / 28.	40.7	41. / 30.	41.7 / 26.0	39.2 / 24.1	42.9 / 28.7	37.8 / 20.4	39.1 / 21.7	41.0 / 23.0	4.3 / 2.0	5.4 / 2.7	45.0 / 14.2	45.1 / 21.3	46.4 / 20.0	41.1 / 15.4	46.8 / 25.9	41.1	39.0 / 27.0	42.7 / 27.9	47.4 / 30.1	44.3 / 27.3
Home	16.2	13.5	13.6	} 7.		} 7.	9.4	9.0	11.0	8.0	7.6	6.0	19.2	20.6	15.3	15.6	17.4	7.7	6.1		5.0	5.7	11.5	10.2
Night and Holiday	1.0	1.7	1.4	}		}	1.4	1.0	1.1			1.7						1.4	2.1					0.6
Hospital[b]	3.9	4.0	3.8	5.		5.	3.6	3.7	3.5	9.0	9.8	10.3	4.9	5.0	2.7	3.3	3.2	7.6	7.3		7.0	9.1	4.6	4.9
Consultations	3.1	2.4	2.5				1.4	1.5	1.4			0.9	1.3	1.5	7.2	4.9	5.1	0.9	1.3				1.2	1.1
X-Ray Services Diagnostic	6.7 / 5.8	6.1 / 5.7	6.2 / 5.8			9.	5.8	6.5	6.3 / 5.3	7.4	6.6	6.0 / 5.6	6.5	5.5	7.2	8.2	7.0	7.2 / 6.4	8.1 / 7.5	8..	9.0	8.5	11.0 / 10.6	8.0 / 4.4
Therapeutic	0.9	0.4	0.4	20.	13.6				1.0									0.5	0.6				0.4	0.4
Laboratory and Other Diagnostic Procedures	0.6[c]	0.6[c]	0.5[c]			5.	1.3	1.4	1.7	4.7	4.0	3.2	1.7	1.2	-	-	4.0	2.8	4.2	3.1	5.0	4.2	3.9	2.9
Surgical Operations	31.2	30.6	30.5			33.	31.5	30.6	28.4	31.9	31.2	30.6	23.9	22.3	25.2	27.9	[illegible]	34.7	29.4	36.1	32.0	30.1	28.7	30.4
Surgical Assistants							0.3	0.1	0.1	0.9	1.2	1.3						1.6	1.3				0.2	
Anaesthetists	5.3	4.9	5.0			5.	6.1	6.0	5.3	4.1	4.2	4.2	3.7	3.5	6.3	5.7	[illegible]	4.9	4.5	4.1	4.0	3.8	-	4.2
Confinements	3.7	3.3	4.1	40.	45.7	7.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7.1	8.8	10.2	8.0	8.2	3.7	6.4
Refractions	1.0	1.4	1.2	-	-	-	1.6	1.8	1.8						1.5	1.8	1.8	-	-	-	-	-	2.3	0.8
Other[d]	5.3	6.8	4.8	-	-	-	5.7	5.8	5.4	2.6	2.7	2.0	6.5	[illegible]				2.5	1.3	2.1	3.0	2.5	2.9	3.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	[illegible]	[illegible]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0[f]

Source: Data provided by individual plans.

(a) Although these are all comprehensive plans, the per capita expenditures of any two plans cannot be compared, since each plan has different waiting-periods and other limitations; each uses a different fee schedule, some paying all-inclusive rates for surgery and confinements; each plan's members demand different volumes of services; and all plans have not a uniform method of reporting costs of services.
(b) For most plans, hospital calls do not include calls in surgical and obstetrical cases.
(c) Including only B.M.R.'s and E.K.G.'s. Most laboratory and diagnostic services are included with office calls for this plan.
(d) Including Special Services, and any residual items not listed above.
(e) Individual averages do not add to this figure since these averages were obtained by dividing total expenditure reported for each item by the enrollment of plans reporting the item.
(f) Because of the problem mentioned in footnote (e), these percentage figures are based on total expenditure for each item, rather than on per capita figures.

Note: Dash (-) means information not available.

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APPENDIX VII

NUMBERS OF SERVICES PER THOUSAND MEMBERS PER YEAR, BY TYPE OF SERVICE, ONE "COMPREHENSIVE" PLAN 1944 - 1951

Type of Service	1944	1945	1946	1947	1948	1949	1950	1951
Physicians' Calls								
Office	1935.9	1949.2	2050.7	2048.7	2211.6	2138.4	1852.8	1950.0
Home	461.2	425.9	502.4	511.6	550.8	550.8	477.6	547.2
Hospital	136.9	150.3	216.4	236.3	297.6	345.6	348.0	367.2
Night - Home	29.3	24.4	32.4	46.0	61.2	62.4	43.2	42.0
Consultations	24.3	22.4	21.8	29.4	28.8	32.4	32.4	32.4
Annual Medicals - Office	13.7	14.8	14.7	12.9	26.4	26.4	21.6	18.0
Extra Patient - Home	(a)	(a)	(a)	(a)	(a)	(a)	27.6	73.2
Pre- & Post-Natal - Office	(a)	(a)	(a)	(a)	(a)	78.0	211.2	199.2
Surgery								
Appendectomies	15.0	12.1	10.4	11.0	10.8	8.4	7.2	7.2
Eye, Ear, Nose and Throat	5.2	5.2	4.6	(a)	(a)	(a)	(a)	(a)
Pelvic & Perineal	4.8	7.8	7.4	(a)	6.0	6.0	4.8	4.8
D. & C's.	(a)	(a)	4.9	4.8	6.0	4.8	6.0	6.0
Tonsillectomies	39.3	27.6	24.1	24.6	34.8	32.4	25.2	24.0
Circumcisions	9.1	10.6	13.1	11.5	13.2	13.2	12.0	12.0
All other	34.6	29.9	17.9	21.8	94.8	85.2	96.0	102.0
Assistants	22.2	23.7	17.7	20.1	25.2	4.8	1.2	1.2
Anaesthetists	76.5	66.9	60.4	65.5	87.6	85.2	78.0	73.2
Fractures	7.5	9.7	8.6	8.7	12.0	12.0	12.0	12.0
Confinements	26.5	23.9	31.0	27.8	27.6	26.4	26.4	25.2
X-Ray and Other Diagnostic								
X-Ray Diagnostic	60.3	68.9	78.2	107.9	115.2	96.0	102.0	108.0
B.M.R.'s	(a)	(a)	10.7	10.8	9.6	9.6	9.6	9.6
E.K.G.'s	(a)	(a)	6.3	6.1	7.2	9.6	10.8	10.8
Cystoscopies	(a)	(a)	4.0	3.2	3.6	3.6	4.8	6.0
Miscellaneous								
Immunization & Injections	288.6	321.6	389.8	320.3	380.4	382.8	351.6	336.0
Refractions	36.3	37.6	33.3	24.4	50.4	57.6	61.2	52.8
Other	95.2	138.9	31.3	67.0	93.6	128.4	135.6	130.8
Total	3322.5	3371.3	3592.0	3620.5	4156.8	4200.0	3958.8	4150.8
Percentage Increase in Membership	-0.6	17.1	97.3	187.5	44.4	8.1	24.0	13.3

(a) Included with other items.

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Page	ERRATA
xi	Chart 10 title - "Four Comprehensive" should read "Three Comprehensive".
25	line 2 from bottom - "chose" should read "chosen".
30	Chart 2 Source should read "Table 3".
35	footnote (1) "per persons" should read "per person". delete "for paediatrics". footnote (2) delete "for paediatrics".
40	line 6 "as confinement" should read "at confinement".
42	line 11 "$2000" should read "$200".
58	line 4 "$16000" should read "$1600".
73	line 5 "free of charge" should read "free to charge".
94	Note "100% over" should read "100% of".
97	footnote "$28 million or $13" should read "$27 million or $12.55".
100	line 16 "11 cents on X-rays" should read "11 cents on X-rays, laboratory, and other diagnostic services".
120	line 2 from bottom - "that" should read "than".
131	Footnote (c) "Control" should read "Contract".
156	line 6 from bottom - "Plan 5's" should read "Plan 4's".
157	third line of chart 10 title - "FOUR" should read "THREE".

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